2021

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Kansas

State Child Death Review Board

2021 Annual Report
(2019 Data)

www.ag.ks.gov/scdrb

KANSAS
ATTORNEY GENERAL

DEREK SCHMIDT

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Kansas Attorney General Derek Schmidt

September 30, 2021

Dear Fellow Kansans:

For nearly three decades, dedicated professionals serving on the State Child Death Review Board have worked diligently to review the causes of child death in our state. They toil to compile meaningful data and analysis that can be the basis for actions that will make our children safer. This year, as always, I am grateful for their service.

This report compiles and evaluates information collected from 2019, the most recent year for which data is available. It provides analysis, context and "prevention points" – recommendations for action that can help prevent similar deaths in the future. It also makes several public policy recommendations intended by the Board to reduce child mortality.

I hope this information will add to the many discussions about efforts in Kansas, both together and individually, to make our state a safer place for our children to grow up. As one of the great Kansans, Dwight David Eisenhower, said after the death of his young son, "There's no tragedy in life like the death of a child. Things never get back to the way they were."

Best wishes,

Derek

Derek Schmidt
Kansas Attorney General

Executive Summary

Since 1994, the Board has reviewed 12,028 child deaths. In 2019, Kansas had 362 child fatalities. The manners of death are classified into one of the following five categories:

Natural – death brought about by natural causes such as prematurity, congenital conditions, cancer, and disease. Natural death remains the category with the most deaths: 212 in total. Of those cases, 38% were due to prematurity, 34% were due to congenital anomalies, and 7% were due to cancer.

Unintentional Injury – death caused by incidents such as motor vehicle crashes, drowning or fire, which were not the result of an intentional act. In 2019, there were 65 total unintentional injury deaths with the leading cause of death being motor vehicle crashes (MVC). Thirty children died because of an MVC. In only two of the MVC deaths, the decedent was the driver of a vehicle. While historically, the 15-17-year-old age group accounts for the majority of the MVC deaths, the rate of death for this age group decreased significantly, with only 6.7 deaths per 100,000 population occurring for this age group in 2019.

The second most prevalent unintentional injury death was asphyxia. In 2019, 12 children died due to unintentional asphyxia. Of the 12 asphyxial deaths, 10 were infants under the age of one, and two were between the ages of one and four.

Homicide – death due to an intentional act, unintentional act, or criminally negligent act leading to the death of another human being, including Child Abuse Homicide and Gang-Related Homicide. There were 23 child homicides in 2019; eight were the result of child abuse and two were the result of gang violence.

In three of the 23 homicides (13%), the board found there was sufficient additional information or evidence to classify the deaths as homicides even though they were not originally classified in that manner on the death certificate.

Suicide – death due to the intentional taking of one's own life. There were 28 suicide deaths, six of which were age 14 or younger. In 2019, Kansas saw the rate of youth suicides decrease from the previous year, which is the first time since 2014 that youth suicides decreased instead of increasing. Of the 28 youths who died by suicide, 61% had concerns regarding their education, whether academically or behaviorally. In 43% of the deaths, the youth had a history of substance use/abuse.

Undetermined – cases in which the manner of death could not be identified from the evidence collected. In 2019, 34 cases were classified as Undetermined with 28 being further classified as a sleep-related Sudden Unexpected Infant Death (SUID). Of the deaths listed as undetermined, 88% were children less than 1 year of age.

Legislative Priorities

The Board strongly encourages the members of the State Legislature to consider each of the Public Policy recommendations, beginning on page 63, during the 2022 legislative session. The two recommendations below are prioritized by the Board to strengthen Kansas's child fatality review processes and child welfare system.

1.) **Consider Statutory Modifications to KSA 22a-243-** With passage of HB 2158 during the 2021 Legislative Session, the SCDRB is now able to share information with and support the work of Local Fatality Review Teams. As the Board has worked through the process to establish rules and regulations, it has become clear that additional statutory modifications to KSA 22a-243 will be needed to ensure that local fatality teams have defined processes and goals, and are functioning within protective parameters. The State Child Death Review Board believes that statutory changes should be made to protect information distributed to the Local Fatality Review Teams. Currently, once the SCDRB distributes information to the Local Fatality Review teams, the information no longer is subject to the same confidentiality protection.

2.) **Improvement to Child Welfare System-** Through the review of more than 12,000 child fatalities since 1994, which includes the social circumstances of the lives of those children, there is an ever-increasing awareness that our social welfare system is directly connected to the potential prevention of child fatalities in our state. The board sees opportunities in this area to improve the outcomes for our children.

   During the 2021 Kansas legislative session, Adrian's Law was passed. The bill was named for a 7-year-old Kansas City, Kansas, boy who died in 2015. Although Adrian's Law requires visual observation of an alleged victim of child abuse or neglect as part of an investigation by DCF or law enforcement officials, it does not address the need to determine if a child may have injuries not readily apparent to CPS investigators who do not have specialized medical training. The Board recommends legislation to require a medical evaluation by a child abuse pediatrician or other pediatric health professional with specialized training in detecting and assessing potential child abuse injuries when there are allegations of child abuse. It is not uncommon to find underlying injuries or evidence of neglect that were missed, or trauma for which the significance of the mechanism of injury was not recognized by the child protective service investigator. Other states have developed training programs for pediatricians to be able to evaluate children with specific types of injuries when child abuse is a concern. Those pediatricians are then eligible for reimbursement from the state for those evaluations, provided they continue to meet the qualifications of the program. This program takes the load of the additional medical referrals off the limited number of board-certified child abuse pediatricians, who will continue to evaluate the more complex and hospitalized cases.

Contents

Acknowledgments

The review of each child death in Kansas could not be accomplished without the invaluable commitment of many people across the state. The Kansas State Child Death Review Board (SCDRB) remains grateful for the significant contributions of the Office of the Attorney General, county coroners, law enforcement agencies, the Department for Children and Families (DCF), the Kansas Department of Health and Environment (KDHE), physicians, hospitals, child advocates, county and district attorneys, and all others who offer their assistance in supplying the information necessary for our review.

As a multi-disciplinary, multi-agency volunteer Board, we appreciate the support of our employers who allow us time to fulfill our responsibilities as Board members.

SCDRB SERVES AS A CITIZEN REVIEW PANEL

The Federal Child Abuse Prevention and Treatment Act (CAPTA) requires each state to establish citizen review panels in order to receive federal funding for child abuse prevention services. The purpose of the citizen review panels is to determine whether state and local agencies are effectively discharging their child protection responsibilities. The Kansas State Child Death Review Board serves in the capacity as one of the three Citizen Review Panels in the State. In addition to the SCDRB, the Kansas Intake to Petition Panel and Kansas Custody to Transition Panel serve as citizen review panels.

The citizen review panels, as a group, are required by CAPTA to accomplish the following:

- Measure agency performance by determining whether the state agency complies with the state CAPTA plan, including the state's assurances of compliance with federal requirements contained in the plan.
- Determine the extent of the agencies' coordination with the Title IV-E foster care and adoption systems and the review process for child fatalities and near fatalities.
- Prepare and make available to the public an annual report summarizing the panels' activities.
- Review policies and procedures of state and local agencies to evaluate the extent to which the agencies are effectively discharging their child protection responsibilities.
- Provide for public outreach and comments in order to assess the impact of current policies, procedures and practices upon children and families in the community.
- Provide recommendations to the State and public on improving the child protective services system at the state and local levels.

More information regarding the Citizen Review Panels in Kansas can be found at:
http://www.dcf.ks.gov/services/PPS/Pages/CitizenReviewPanel.aspx

Board Members

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Senior Assistant Attorney General, Topeka

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Commissioner of Education appointee

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Diane C. Peterson M.D. (District Coroner Member),
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Attorney General appointee to represent advocacy groups

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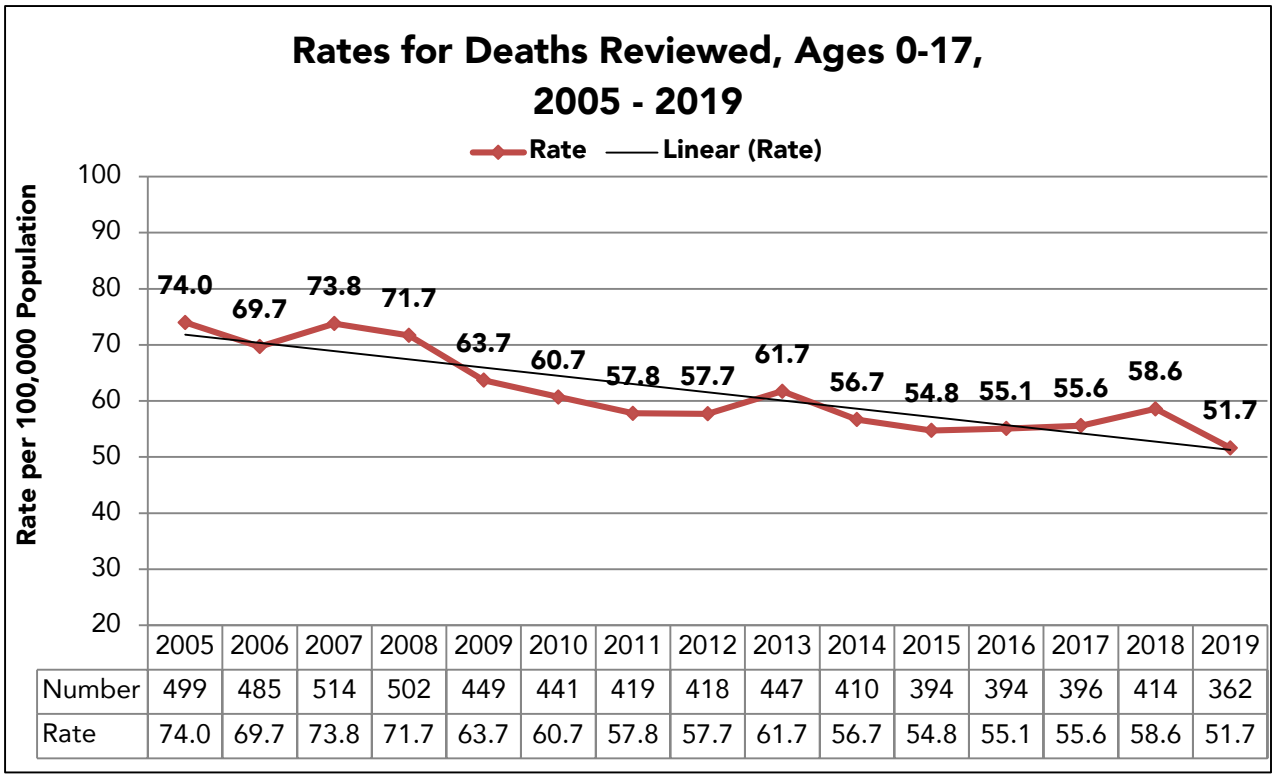
Sarah L. Shipman, Deputy Attorney General, General Counsel, State Child Death Review Board

2019 Overview

The State Child Death Review Board reviewed the deaths of 362 children, ages 0-17, who died in Kansas, or were Kansas residents who died outside of the state during the year 2019. The death rate calculated per 100,000 Kansas children has decreased in calendar year 2019 with a continued downward trend from previous years. (Figure 1).

Figure 1



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Number	499	485	514	502	449	441	419	418	447	410	394	394	396	414	362
Rate	74.0	69.7	73.8	71.7	63.7	60.7	57.8	57.7	61.7	56.7	54.8	55.1	55.6	58.6	51.7

Figure 2

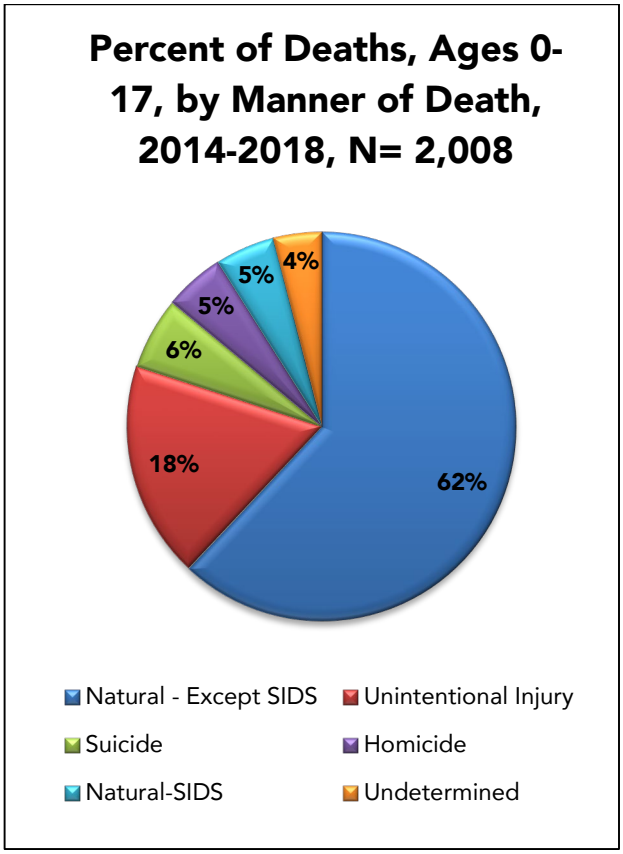
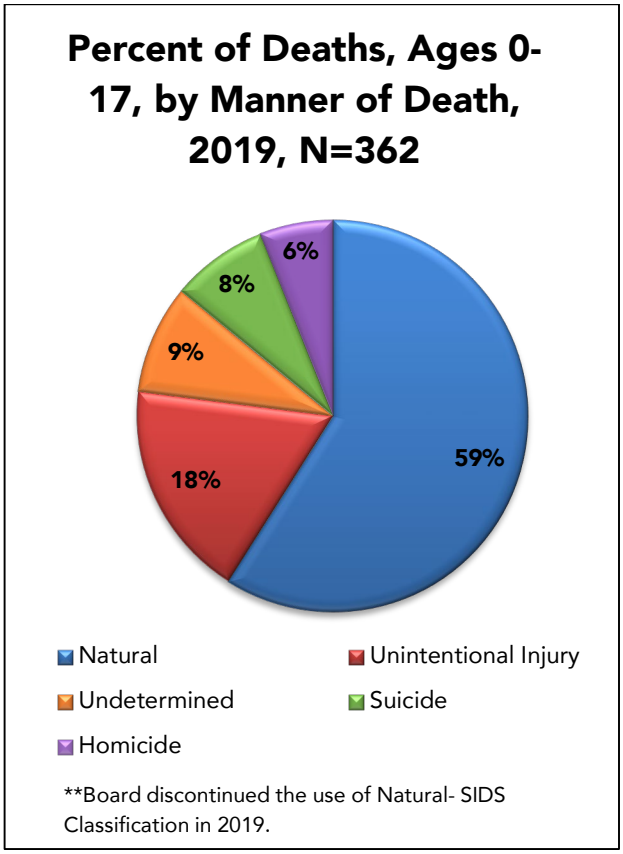


Figure 3



As shown in Figures 2 and 3, death by natural manner has accounted for the largest percentage of deaths for the previous five years as well as the current year. In 2019, death by natural manner claimed the lives of 212 Kansas children (Figures 3 and 4).

Of the total deaths in 2019, 18% were due to unintentional injuries, 9% were of undetermined manner, and 8% were due to suicide. The relative percentages of manners of death are all comparable to the previous five reporting years except infant deaths due to SIDS, which is no longer a classification of death used by the Board. The deaths previously categorized as Natural-SIDS are now being categorized in subgroups of Sudden Unexplained Infant Deaths (SUID) within the Undetermined Manner, as explained in the Sleep-Related, SUID Deaths section of the report on page 13.

Males accounted for more deaths in all age groups and comprised 59% of all child deaths in 2019 (Figures 4 and 5).

Children who were less than 29 days of age accounted for 61% of natural deaths. Children ages 29 days to one year accounted for 12%. Prematurity and congenital anomalies accounted for 72% of the natural deaths. Cancer claimed the lives of 15 children and was the third-leading natural cause of death (Figure 6).

Figure 4

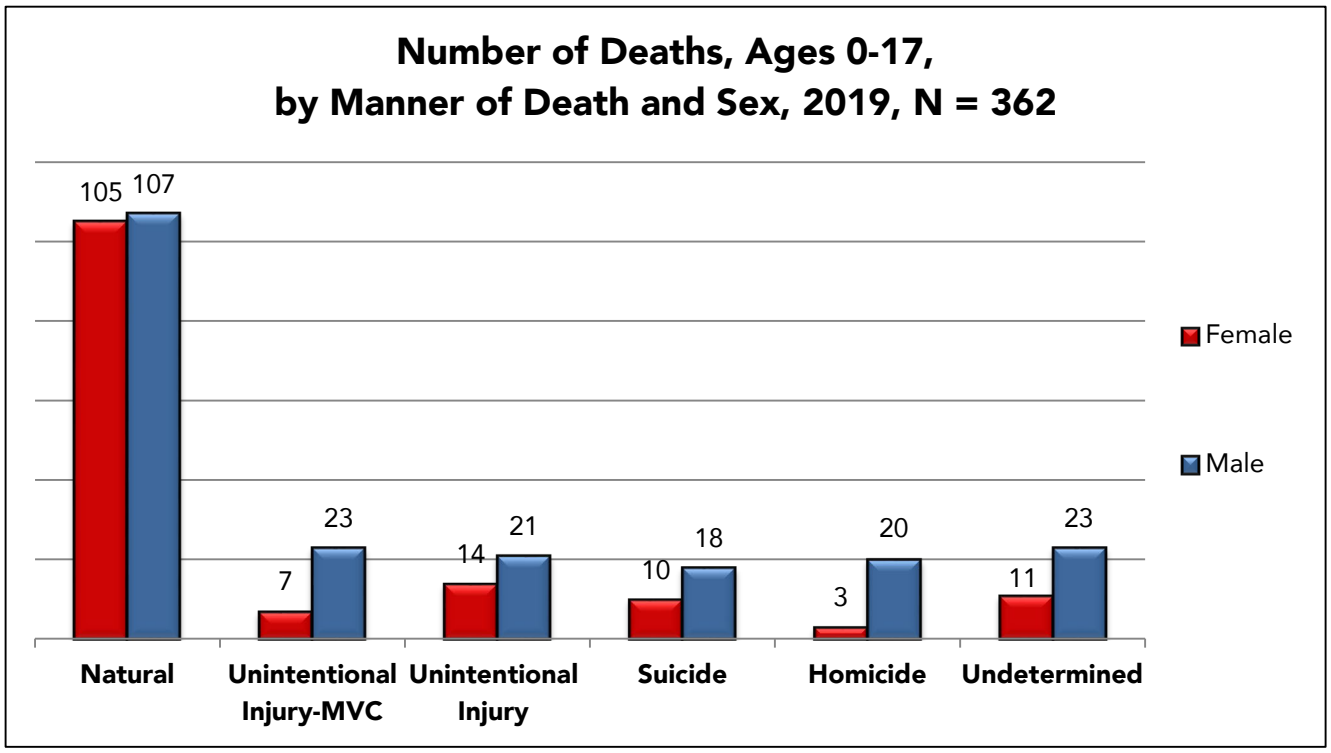


Figure 5

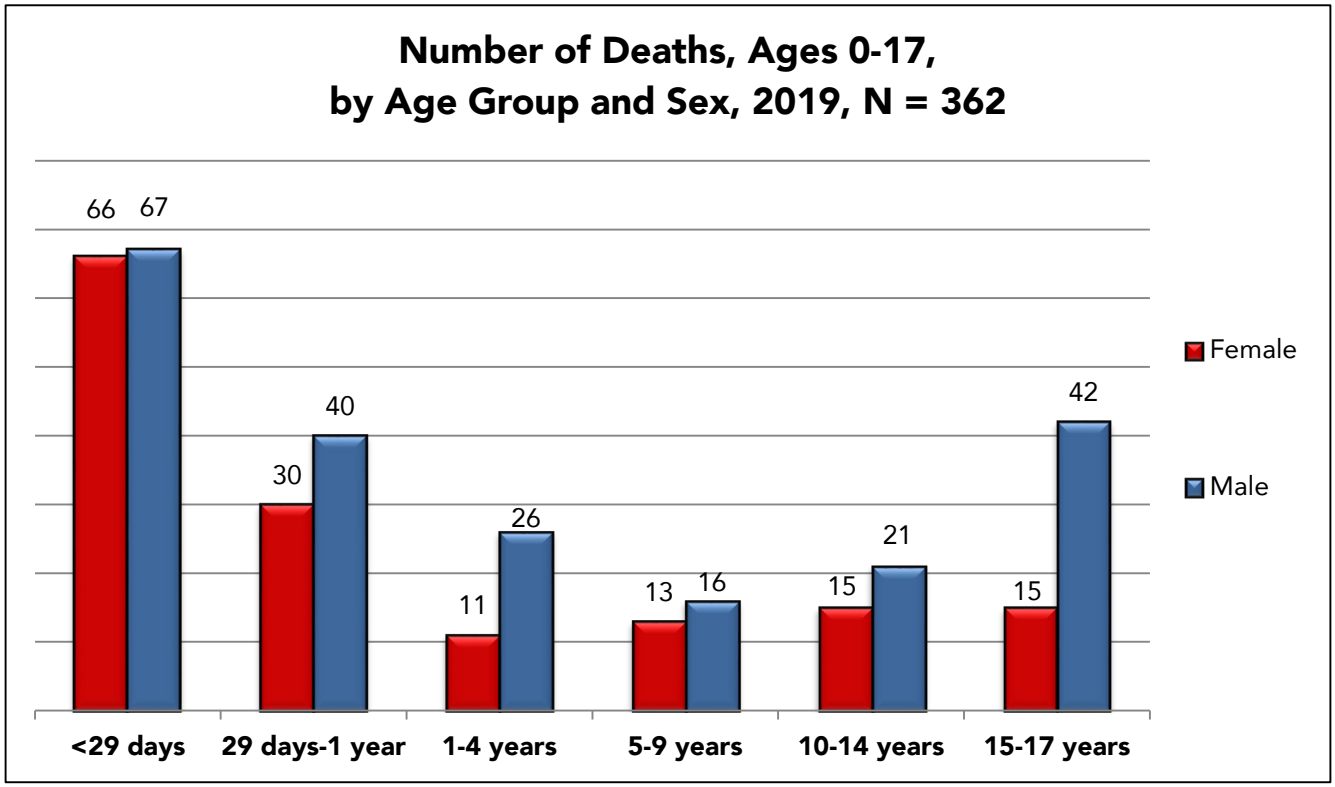
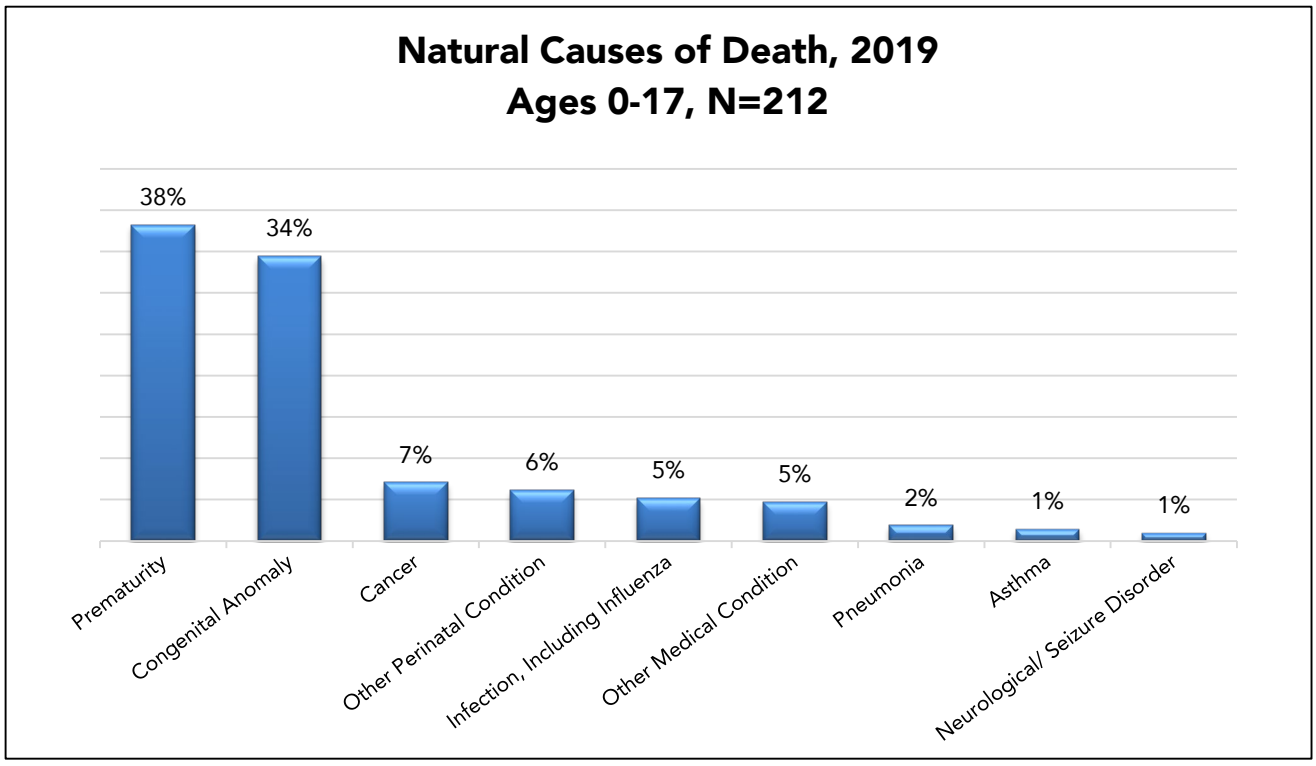


Figure 6


Natural Causes of Death, 2019
Ages 0-17, N=212
38%
34%
7%
6%
5%
5%
2%
1%
1%
Prematurity
Congenital Anomaly
Cancer
Other Perinatal Condition
Infection, Including Influenza
Other Medical Condition
Pneumonia
Asthma
Neurological/ Seizure Disorder

Child Welfare Overview

While there is an expectation for all caseworkers, providers and administrators serving in our child welfare system to be highly trained, dedicated professionals, we cannot expect each of them to be an expert in every area of involvement with families. Ensuring the safety of more than 700,000 children in Kansas is a shared responsibility that extends to law enforcement, public health, medical and mental health professionals, educators, childcare providers, and private citizens.

Through the review of more than 12,000 child fatalities since 1994, which includes the social circumstances of the lives of these children, there is an ever-increasing awareness that our social welfare system is directly connected to the potential prevention of child fatalities in our state. The board sees opportunities in this area to improve the outcomes for our children.

As shown in Figure 7, of the 362 child fatalities reviewed by the Board in 2019, 130 of the cases had history with the child welfare system, specifically with Department for Children and Families (DCF) Division of Child Protective Services (CPS). Of the 130 deaths with past CPS history, in 37 cases the decedent or a sibling had been removed from the home at some time prior to the death (Figure 8). Also noted in Figure 8 are the ages of children in state's custody at the time of their death as well as those in which there were open cases at the time death.

Figure 7

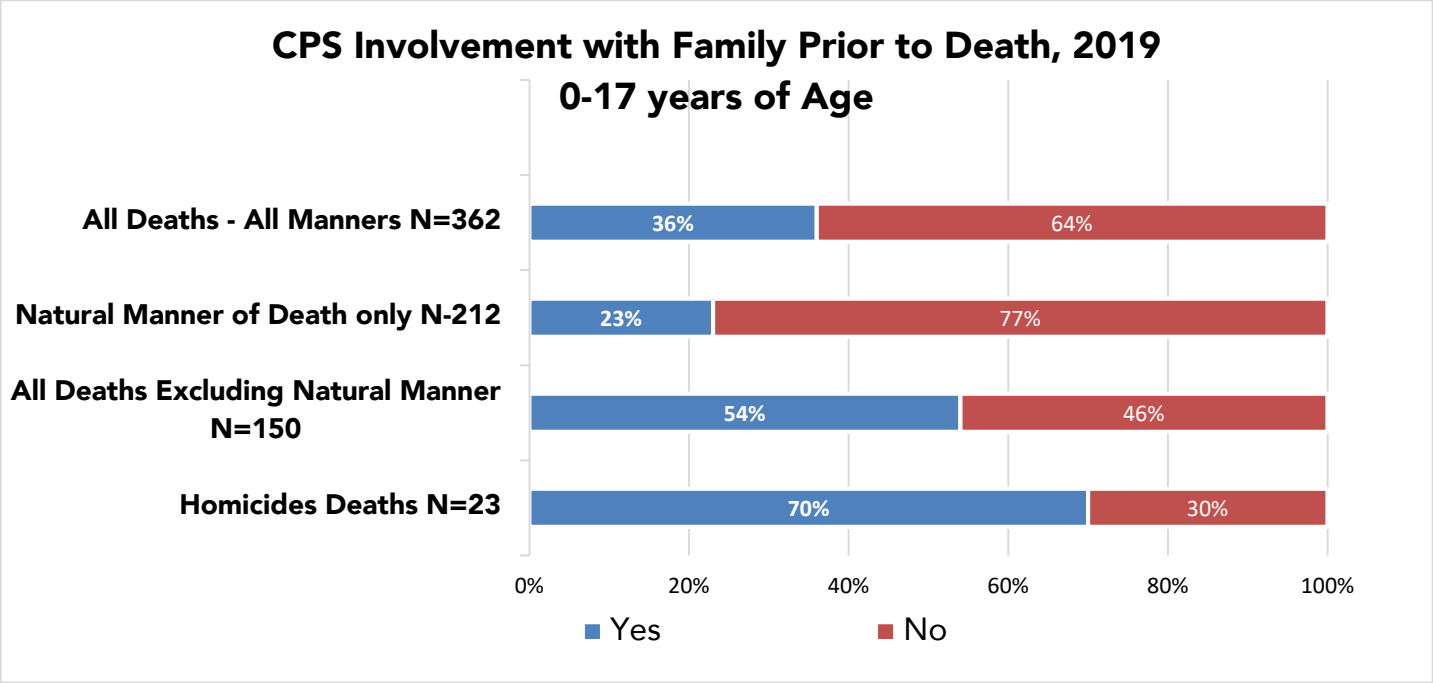
Number of child deaths, All Cause and Manners, age 0-17 years, by involvement with Child Welfare System N=362						
	Total-All Ages	**Age <1**	**Age 1-4**	**Age 5-9**	**Age 10-14**	**Age 15-17**
No Known CPS History	232	155	17	18	16	26
CPS History Prior to Death	130	48	20	11	20	30

Figure 8

Type of case history when decedent had CPS history prior to death, 0-17 N=130* *Categories are not exclusive as cases will overlap and equal more than 130						
	Total- All Ages	**Age <1**	**Age 1-4**	**Age 5-9**	**Age 10-14**	**Age 15-17**
Removal of Sibling or Decedent Prior to Death	37	15	6	1	4	11
Open CPS at Time of Death	17	6	4	2	2	3
Decedent in Custody at Time of Death	8	3	2	0	0	3
Decedents with history not described in above categories	88	31	13	8	16	20

Overall, 36% (130) of decedents had CPS involvement prior to their death. As shown in Figure 9, for those children that died from a Natural Manner of death, only 23% (49) of the 212 decedents had CPS involvement. However, when Natural Manner is excluded, the percentage of cases with CPS involvement increases, which is especially notable in the Homicide category where 70% of the cases had prior CPS involvement.

Figure 9



In 2016, The Commission to Eliminate Child Abuse and Neglect Fatalities published a national report entitled, "Within our Reach," which focused on child welfare system changes that could lead to prevention of child abuse and neglect deaths. Consistent with the Commission's research and findings, data from the SCDRB supports the following:

- Infants and toddlers are at a higher risk of abuse or neglect fatalities compared to other age groups.
- A call to a child protection-reporting center, regardless of the disposition, is the best predictor of a later child abuse or neglect fatality. This highlights the importance of how decisions are made to screen in reports. Screening out a report risks leaving children in unseen situations where there may be a high risk for later fatality or serious injury.
- Involvement of health care and public health agencies and professionals is vital to safety for children. Well-coordinated interagency efforts are essential in ensuring timely and accurate communication and effective family services.
- The importance of child protection workers' access to real-time information about families cannot be overestimated.
- It is critical to have an accurate count of child protection fatalities. Better data allows us to better understand what works and how best to use resources and guide research.

As suggested in the Legislative Priorities Section, the Board believes that additional child welfare improvement is needed in Kansas to reduce the number of child abuse and neglect deaths.

VIGNETTES

DEATHS WITH CHILD WELFARE INVOLVEMENT

1.) DCF had 36 previous reports on the family of a child abuse homicide victim, many of which included allegations of physical abuse. None of these prior cases were either substantiated or affirmed, yet the board could find no incidents in which the child or siblings had physical examinations by a healthcare provider to assess for injuries or other indications of abuse, which might have provided the evidence needed to remove the children from their dangerous environment.

2.) A teen in state custody at the time of their death by suicide was experiencing volatile situations in a foster home. The Board found that local law enforcement had shared concerns about this environment with the state contractor several times and suggested the teen be placed in a different home. The night prior to the death, law enforcement warned the state contractor something bad would happen if the teen was returned. The child died the following day, after having been returned to the foster home.

3.) A child between 5-9 years of age, died from complications of methamphetamine intoxication. There had been multiple reports to DCF regarding the parents and their substance abuse and on two prior occasions, siblings were placed in state custody due to parental drug use. Two weeks prior to this child's death, a report was made to DCF regarding concerns about the welfare of this child. At the time of the Board's review it appeared that both DCF and Law Enforcement were unaware of the autopsy toxicology findings that indicated the death was the result of methamphetamine intoxication. Both agencies had closed their respective cases indicating the child had died from natural causes, potentially leaving other children at risk and overlooking criminal investigation information.

Mortality Affecting Infants

In Kansas, special emphasis has been placed on infant mortality (age less than 1 year) as an area in need of improvement. There were 203 infants who died in 2019. The infant mortality rate for Kansas was 5.7 deaths per 1,000 live births and was the lowest Kansas has experienced since the Board's creation in 1992. (Figure 10).

Figure 10

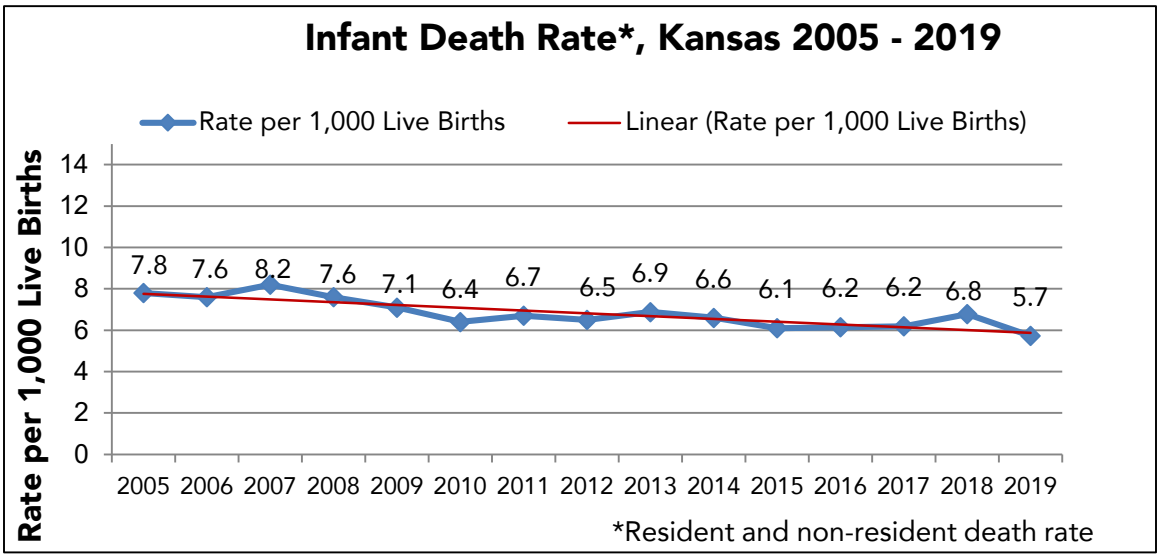


Figure 11

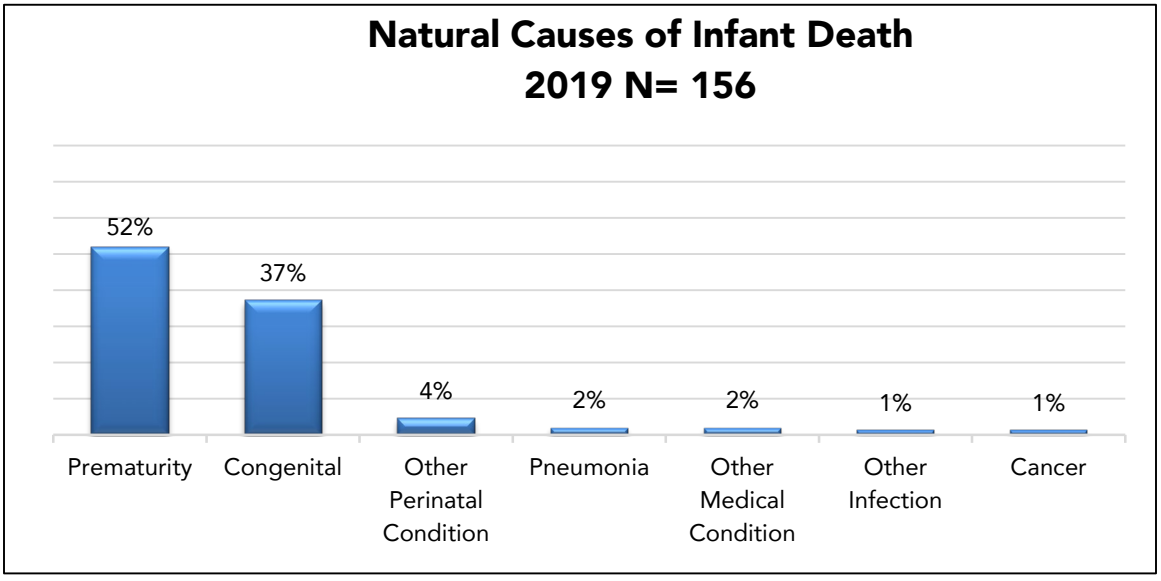
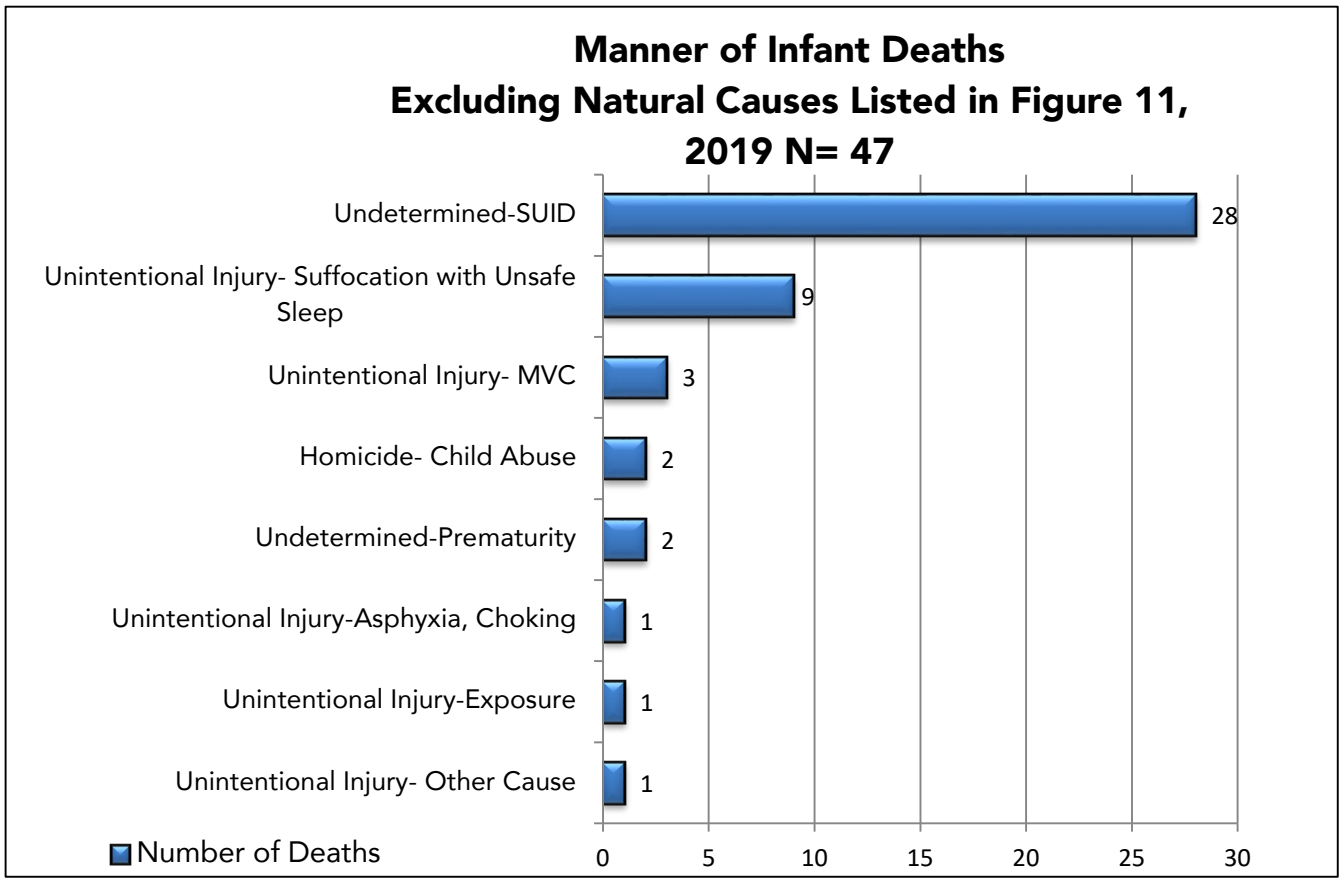


Figure 12



Of the 203 infant deaths in 2019, 77% (156) were due to natural causes such as prematurity and congenital anomalies (Figure 11). The remaining 23% (47) were due to reasons other than identified natural causes (Figure 12). It is important to note that of the 47 infant deaths that were non-natural, 79% (37) were sleep-related and account for the two largest categories of non-natural infant deaths.

As shown in Figures 13 and 14, 62% of the infants who died from natural causes were born at 31 weeks gestation or earlier. Though the majority (90%) of infants are born at or after 37 weeks gestation, deaths are disproportionately associated with those born prior to 37 weeks gestation. In addition to being a direct cause of death, prematurity is a significant risk factor for infant mortality from other causes.

Figure 13

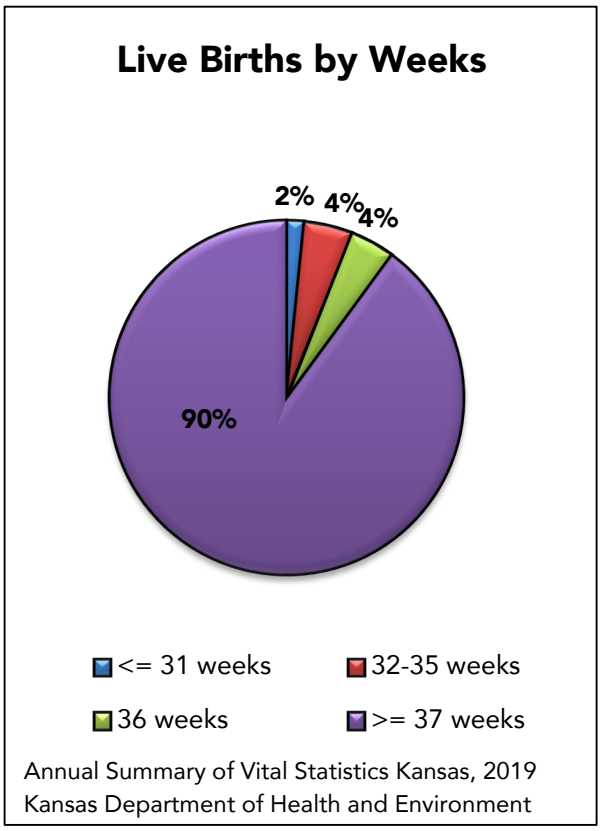
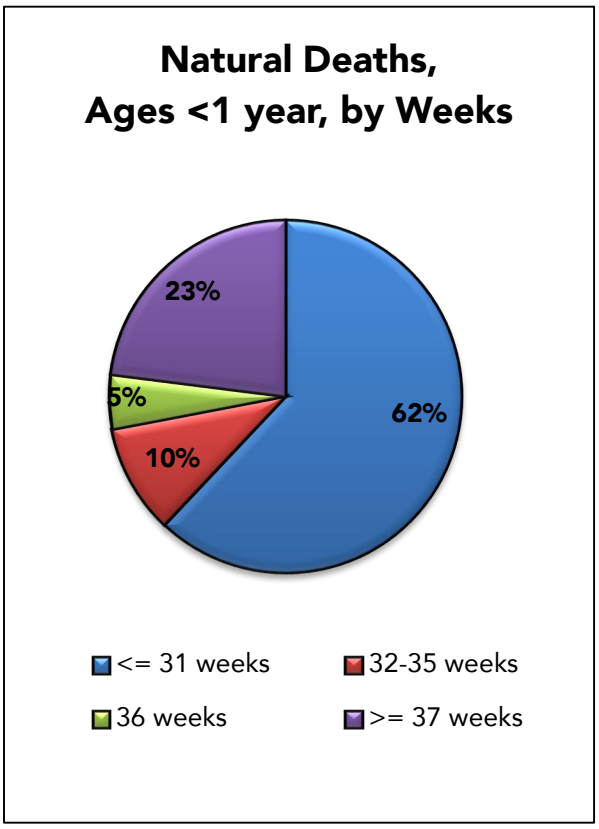


Figure 14



PREVENTION POINTS

- **Prenatal Care** – Medical care during a pregnancy can identify risk factors and health problems, allowing for early treatment and improved outcomes. Proper nutrition is vital to a pregnancy. Iron and folic acid supplements, along with other physician prescribed regimens, can help ensure a healthy pregnancy and newborn.
- **Avoid Drugs, Alcohol, and Nicotine** – The use of illicit substances, alcohol, and nicotine must be avoided during pregnancy. These elements are known to cause serious health problems and increase the risk for death in newborns and infants.
- **Drug Environments** – Children living in environments where they are exposed to drugs (including illicit drugs, prescription medication misuse) and alcohol abuse are at increased risk of abuse, neglect, or death. If caregiver substance abuse is suspected or identified at birth, the safety of the infant and other children should be assessed by DCF and the family provided drug treatment and medical and mental health services in a closely monitored, supportive, trauma-informed system to reduce potential harm.
- **Diagnose and Manage Chronic Health Conditions** – Medical care for infants and children with chronic health conditions can optimize health. Having a medical home is essential for improving such conditions. The medical home is a care delivery model where patient treatment is coordinated through a primary care physician to ensure children receive necessary and consistent care when and where they need it, in a manner that is understood, and in which education and care for chronic conditions and illnesses can be monitored.

Sleep-Related, SUID Deaths

Prior to 2019, sleep-related deaths of infants (less than 1 year of age) were classified in one of three manners of death depending on the circumstances and the cause of death.

1.) Natural -Sudden Infant Death Syndrome (SIDS)
2.) Unintentional Injury-Asphyxia
3.) Undetermined

In an effort to categorize Sudden Unexpected Infant Deaths (SUID) in a standardized process, consistent with practices in other states, the SCDRB is using the SUID Case Registry Decision-Making Algorithm beginning with the review of 2019 infant sleep-related fatalities. These categories of SUID cases as listed in Figure 15, are replacing the previous categories of Sudden Infant Death Syndrome used in the review of cases prior to 2019. More information regarding the SUID case registry and its application can be found at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311566/.

In 2019, there were 37 sleep-related infant deaths. The classifications of these deaths are described below in Figure 15. Both of the Unexplained SUID categories with unsafe sleep factors may also include cases in which there are other potentially fatal findings, concerning conditions, or competing causes of death; however, how these factors contributed to the death is uncertain.

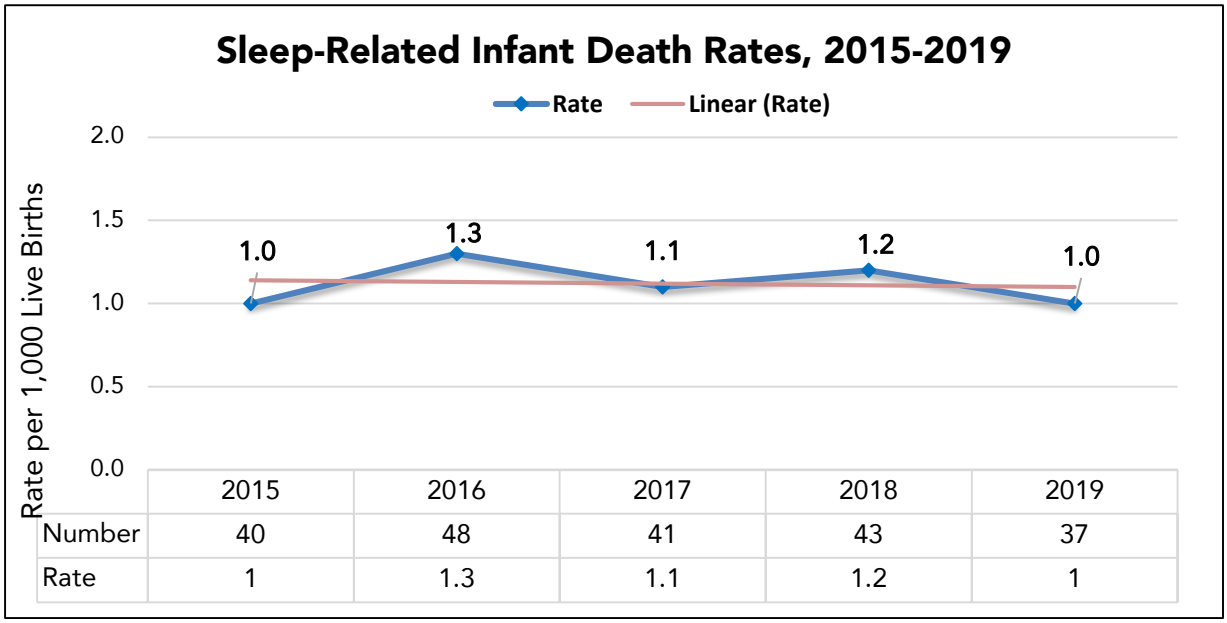
Figure 15

Sleep-Related Death Classifications for Infants N=37		
Undetermined-SUID	**Further Explanation**	**2019 Deaths**
Unexplained: No autopsy or death scene investigation	Autopsy and/or death scene investigation not completed.	**0**
Unexplained: Incomplete case information	Incomplete case information pertinent to case review.	**8**
Unexplained: No unsafe sleep factors	Cases in which the infant was placed alone on his or her back on a sleep surface recommended for an infant without any soft or loose objects in the sleep area.	**1**
Unexplained: Unsafe sleep factors	Cases in which the infant's sleep environment had one or more unsafe sleep factors (e.g. not in a crib, on a shared sleep surface, not supine) but evidence of airway obstruction was not present.	**13**
Unexplained: Possible Suffocation with unsafe sleep factors	Cases in which unsafe sleep factors were present and evidence of what caused at least partial obstruction of the airway is known but does not meet the criteria of the explained suffocation below.	**6**
Unintentional Injury-Asphyxia	**Further Explanation**	**2019 Deaths**
Explained: Suffocation with unsafe sleep factors	Cases with a non-conflicting account of placed and found position, no other potentially fatal findings or conditions from autopsy, age and developmental stage that made a suffocation event possible, evidence to visualize how the airway obstruction occurred and strong evidence of external obstruction of the airway.	**9**

Due to the change in classifications, the Board will no longer classify deaths as Natural-SIDS. Historical information about SIDS related deaths may be accessed in previous annual reports at: https://ag.ks.gov/media-center/annual-reports/child-death-review-board-annual-reports.

As shown in Figure 16, sleep-related infant death rates over the last five years have remained relatively stable. In 2019, the rate of infant deaths from sudden unexpected causes, which includes both Undetermined and Unintentional Injury-Asphyxia SUID deaths during sleep, was 1.0 infant death per 1,000 live births. This rate exceeds the target set by Healthy People 2020, of an infant death rate from these causes to less than 0.84 by 2020.

Figure 16



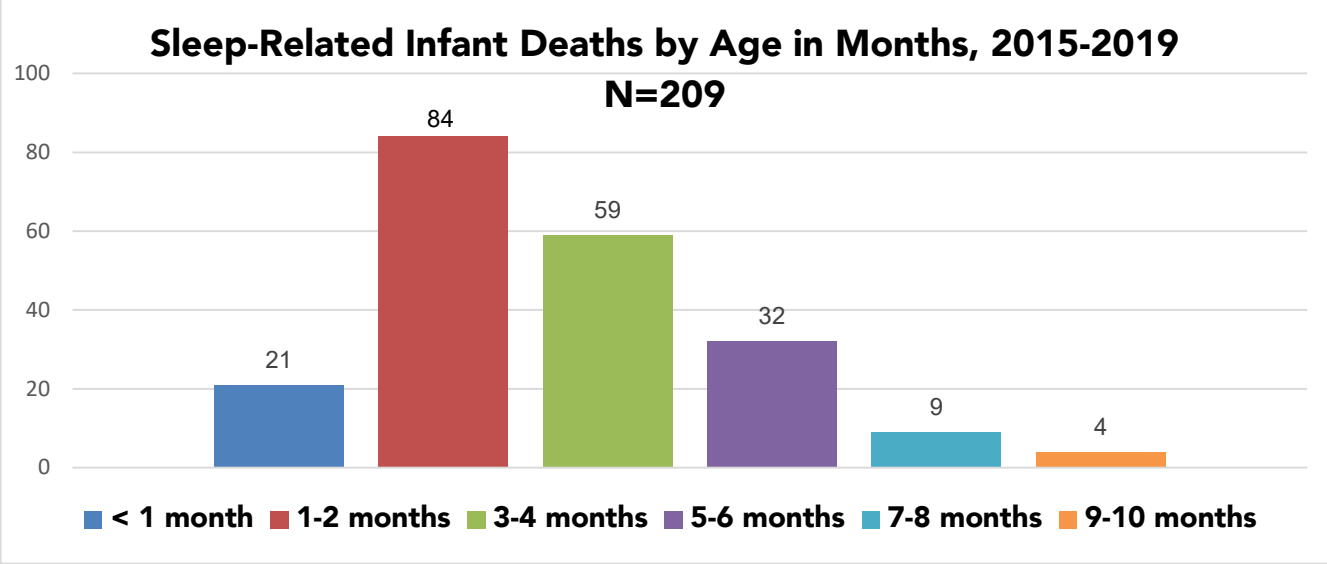
	2015	2016	2017	2018	2019
Number	40	48	41	43	37
Rate	1	1.3	1.1	1.2	1

In 36 of the 37 sleep-related deaths reviewed by the Board in 2019, there was evidence of one or more unsafe sleep practices. The images below depict a safe sleep environment in which the infant is placed Alone, on their Back, and in a Crib. Parents and caregivers should ensure the ABC's of safe sleep, for every sleep.

Photo Credit-KIDS Network http://www.kidsks.org/

Although by definition, sleep-related SUID deaths can occur at any time during an infant's first year, most SUID deaths occur in infants between 1 and 4 months of age as shown in Figure 17.

Figure 17



While most sleep-related SUID deaths occur in the child's home, nearly 20% of the sleep-related fatalities occurred in a location outside the child's home (Figure 18). Safe sleep practices should occur at each sleep (naptime and nighttime) both in the home and when away from the home.

Figure 18

Incident Sleep Location* Infant Deaths, 2015-2019 N=209		
Location	**Number**	**Percent**
Child's Home	**168**	80.4%
Relative's Home	**22**	10.5%
Unlicensed Childcare	**9**	4.3%
Friend's Home	**4**	1.9%
Other §	**3**	1.4%
Foster Care	**1**	0.5%
Licensed Childcare	**1**	0.5%
Unknown	**1**	0.5%

*Multiple responses are appropriate for some circumstances regarding incident location; therefore, the sum could be greater than the total number of infants who died of sleep-related causes.
§ Other includes---hotel rooms, shelters, etc.

Sleep-Related, SUID Deaths, continued

In the 209 sleep-related deaths the Board reviewed from 2015 through 2019, only 21% of the infants were in a crib or bassinet (Figure 19). Also of concern was the 61% of infants who shared a sleep surface with one or more person(s) at the time of the incident (Figure 20).

As recommended by The American Academy of Pediatrics (AAP), infants should be placed on a firm, sleep surface (e.g., a mattress in a safety-approved crib) covered by a fitted sheet with no other bedding or soft objects in the crib. It is also recommended that infants sleep in close proximity to their parents (room sharing) without bed-sharing.

Figure 19

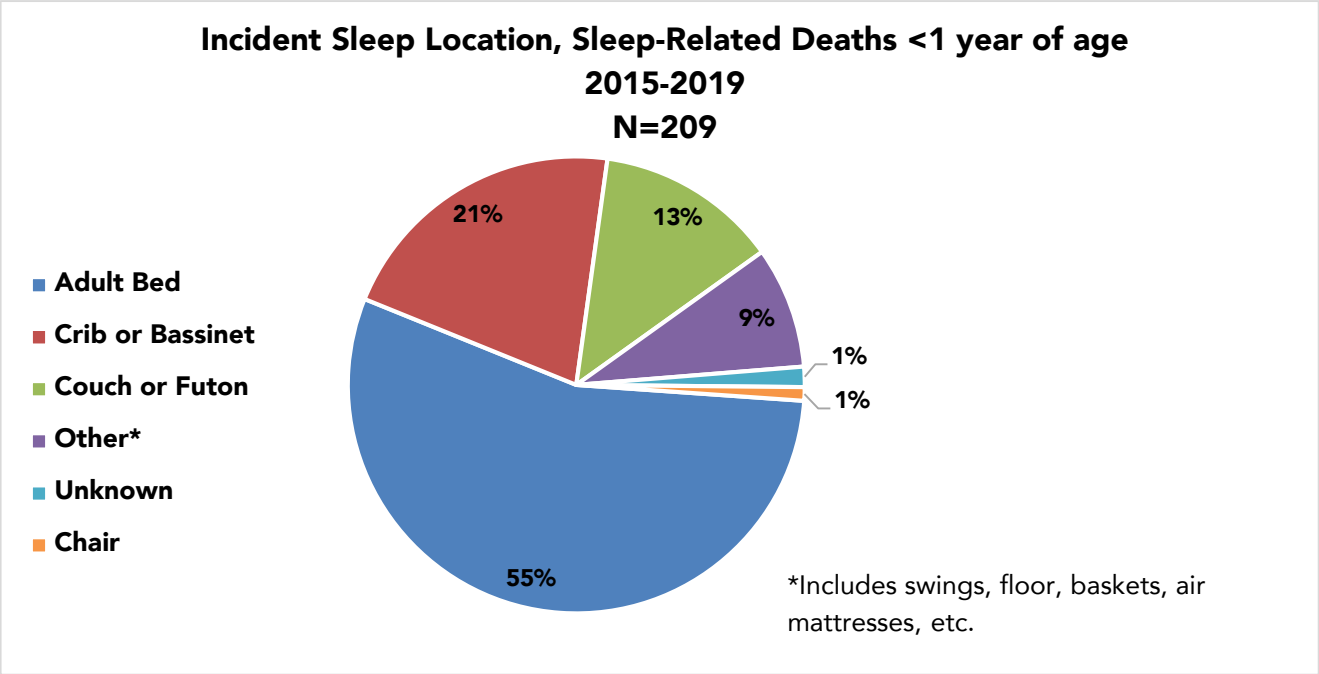
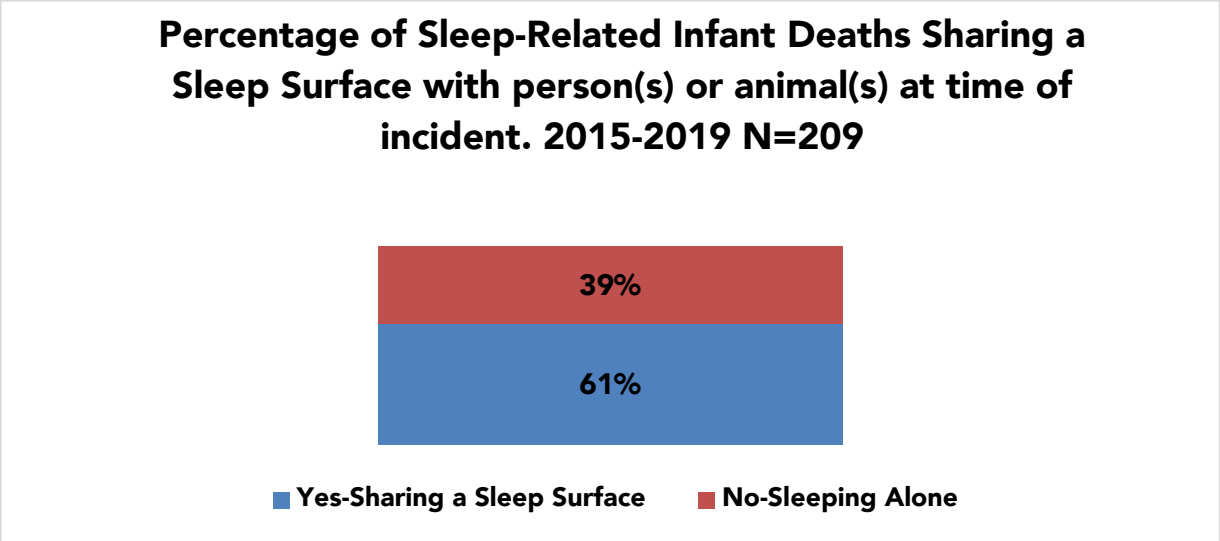


Figure 20



From 2015 through 2019 there have been 33 deaths in which the mother/caregiver reportedly fell asleep while breast (21) or bottle (12) feeding the infant (Figure 21). As noted in the prevention points on page 18, mothers should be encouraged and supported to breastfeed safely. Education about how to safely breastfeed in bed and counseling about risk factors and prevention is critical. Parents should be reminded that if infants are brought to an adult bed for a feeding (breast or bottle), they should be returned to a separate safe surface, crib or bassinet only, when the parent is ready to return to sleep.

Figure 21

Caregiver or Supervisor Fell Asleep While Feeding Infant (2015-2019) N=209		
Caregiver or Supervisor Fell Asleep While Feeding Infant		**Number**
Yes		**33**
If Yes, Feeding Type	Breast	21
	Bottle	12
No		**165**
Unknown		**11**

The Board stresses the importance of thorough investigations by law enforcement and medical personnel, along with properly conducted, complete autopsies. In eight of the 37 sleep-related death investigations in 2019, the Board believed additional investigative information would have been helpful in more clearly determining the manner of death or the circumstances surrounding the death. The recommendations from these cases includes using photographed scene recreations and re-enactments with dolls, additional witness interviews, improving the quality of scene photographs, and

documenting room temperature, the availability of a crib, and the size of the bed. Use of the Center for Disease Control's Sudden Unexpected Infant Death Investigation Form is the expected standard in all investigations and would aid in obtaining critical information at the scene and from interviews: https://www.cdc.gov/sids/SUIDRF.htm

Please refer to Appendix B for county specific information regarding sleep-related infant deaths.

Characteristics of the 37 Sleep-Related Infant Deaths, 2019

- 84% occurred when the infant was sleeping in a place other than a safe crib or bassinet.
- 78% occurred at the child's home, 8% in a relative's home, 8% in unlicensed child care settings, 2% in the home of a friend and 2% in a licensed child care setting.
- 49% (18) had current or past DCF child protective services (CPS) involvement with the family.
  - In 39% of these families (7 cases), either the decedent or sibling(s) were placed into state custody at some time prior to the death.
- 43% were bed or couch-sharing.
- 35% had parental/caregiver alcohol or substance abuse concerns prior to or at the time of death.
- 22% of the investigations lacked information that would normally be expected in a child death investigation.

PREVENTION POINTS

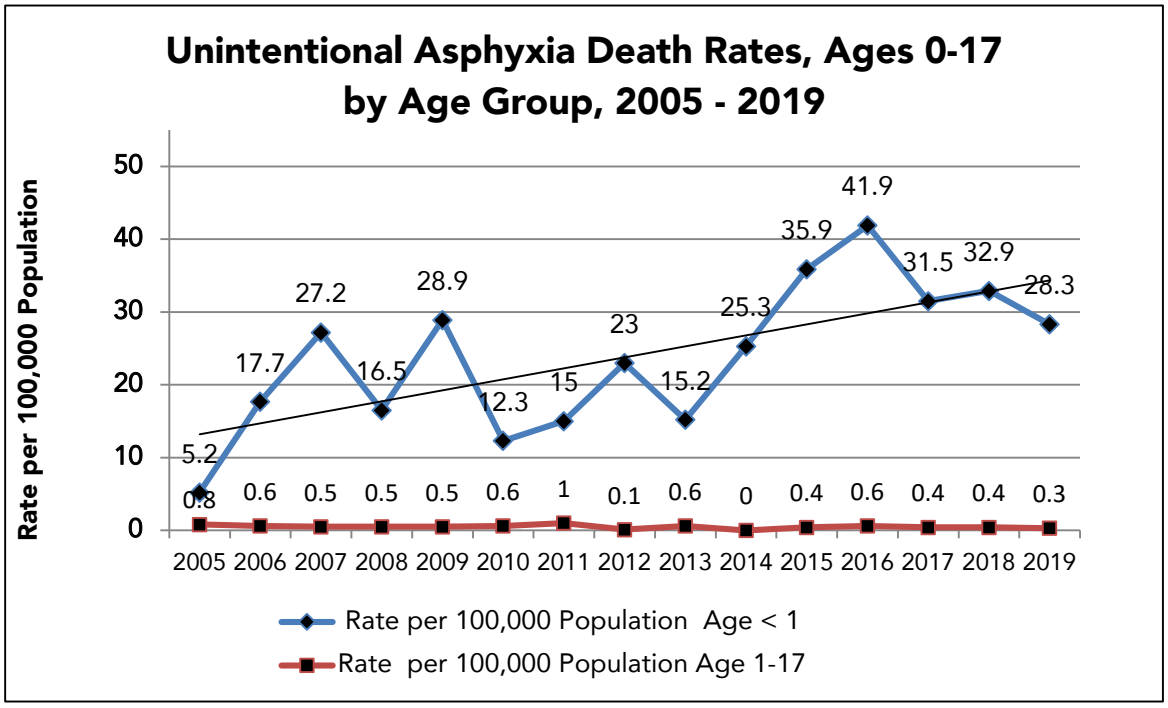
- Infants should be placed to sleep in a supine position. Side sleeping is not as safe as supine sleeping and is not advised.
- A separate, but proximate sleeping environment is recommended. Bed-sharing with adults or other siblings should be avoided. Infants should always be placed on their backs to sleep during every sleep period, including naps. Sleep position should be consistent each time and at every location. When babies who usually sleep on their backs are placed to sleep on their stomachs, they are at a significantly increased risk of sudden death.
- A firm sleep surface should be used. Soft materials such as pillows, quilts, comforters, or sheepskins should not be placed in the crib with the infant.
- Sleep clothing, such as wearable blankets designed to keep the infant warm, should be used instead of blankets and quilts that could overheat the infant or cover the baby's head. Avoid overheating the infant's room.
- Smoking during pregnancy and in the infant's environment are risk factors and should be avoided.

- Mothers should be encouraged and supported to breastfeed, not only for the known nutritional value but as a protective factor against SIDS. Infants brought to the adult bed for nursing should be returned to a separate safe surface (i.e. crib or bassinet) when the parent is ready to return to sleep.
- Many devices promoted to reduce SIDS have not been proven to reduce the incidence of SIDS. Obtain an evaluation/recommendation from a medical professional before use of products such as sleep positioners or wedges.
- For more information on safe sleep, visit these websites: SCDRB at http://ag.ks.gov/scdrb, the AAP at http://www.aap.org/, or Kansas Infant Death and SIDS Network at http://www.kidsks.org/.

Unintentional Injury – Asphyxia Deaths

Twelve children between the ages of 0-17 died in 2019 due to unintentional asphyxia such as suffocation, strangulation, or choking. Of the 12 children who died due to unintentional asphyxia, 10 (83 percent) were under the age of 1. The remaining two deaths occurred to children ages 1-17 and were a result of choking. As shown in Figure 22, the rate of death by unintentional asphyxia in children less than 1 year of age continues to trend upwards, although in comparison to historical data, the more recent annual rates appear to be stabilizing.

Figure 22



Unintentional asphyxia deaths most often affect very young children who have not yet developed the strength or motor skills to remove themselves from dangerous situations. Reviews from Kansas and across the nation show there are several common practices that increase the risk for these deaths. These include sleeping somewhere other than a crib or bassinet, sleeping in a cluttered area, being placed on a soft surface such as an air mattress, pillow or quilt, and bed-sharing[1] with parents or siblings. Of the 12 unintentional asphyxia deaths, 9 were sleep-related. All of the sleep-related, unintentional asphyxia deaths included one or more of the above-described factors as a cause of the suffocation/asphyxia.

Some cribs, bassinets, playpens, and child beds have been recalled because of known or suspected risk of strangulation. Before caregivers purchase furniture for children, they should ensure no recalls have

[1] Bed Sharing- A type of sleeping practice in which the sleeping surface (e.g. bed, couch or armchair, or some other sleeping surface) is shared between the infant and another person.

been issued. The U.S. Consumer Product Safety Commission (http://www.cpsc.gov/) is a resource for recall information.

Characteristics of the 12 Unintentional Asphyxia Deaths, 2019

- 75% (9) of the deaths were sleep-related and occurred in children under the age of 1.
  - All had elements of unsafe sleep.
- 25% (3) deaths were a result of choking on food or an object.
- Two deaths occurred in unlicensed childcare homes.

PREVENTION POINTS

- **Proper Supervision** – Young children should be watched attentively. Leaving them alone for even a few minutes allows opportunities for unintentional injuries. Child-specific training in CPR and other emergency responses can help prevent death.
- **Safe Environments** – Be vigilant about potential dangers to children. Consideration must be given to a child's size, curiosity and motor ability. Living, sleeping, and playing areas should be routinely inspected for dangers such as chests/coolers, hanging cords or plastic bags, which may not be threats to adults, but can be deadly to children. Check play areas for hazards like protruding bolts that can catch clothing and strangle a child. Check playground equipment parts and hand rails for spaces that may be large enough to allow a child's body to slip through causing strangulation by trapping the head or neck.
- **Infant Sleeping Arrangements** – The safest sleeping arrangement for an infant is alone in an approved crib, on his or her back. Babies should not sleep in adult beds and should not be placed in bed with parents or siblings. The crib mattress should be firm and fit tightly in the crib so the child cannot be trapped between the mattress and side of the crib. No other items, including blankets, bumper pads, pillows, stuffed animals or infant supplies should be in the crib with the baby, as they create a risk for suffocation.
- **Choking Hazards** – Children under age 4 are most at risk for choking on food and small objects. In addition to small toys, balloons, coins and some foods can be a choking hazard for young children. Hot dogs, whole grapes, raw carrots, popcorn and other foods can become lodged in the child's airway. Young children need supervision while eating and when playing with or near potential choking hazards.

Deaths in Non-Relative Child Care Homes and Centers

Since many infants and children spend a significant portion of their time in day care or other child care environments, assuring safe sleeping arrangements and compliance with state safety regulations at every site is critical. Parents should talk about safe sleep practices with anyone who will be caring for their baby, including family, friends, babysitters and child care providers.

Many Sudden Unexpected Infant Deaths (SUID) have been associated with the child being prone, especially when the baby is accustomed to sleeping on his or her back. Babysitters and family members who provide periodic care for babies may not be aware of the importance of supine sleeping and other safe sleeping arrangements. In licensed child care settings, it is expected that safe sleep environments and sleep position recommendations be followed. For general information regarding the basis and purpose of child care regulations, please visit https://www.kdheks.gov/bcclr/regs.html.

In the last 10 years (2010-2019), there have been 39 child care deaths in Kansas with six of those occurring in 2019. The six deaths in 2019 equally occurred in unlicensed and licensed child care locations. Children under the age of 1 have accounted for 37 of these deaths. Of those 37 deaths, 32 were sleep-related and all but three had unsafe sleep factors. The other five deaths that occurred to children under the age of 1 and were not sleep-related, included two child abuse homicides and three deaths by natural causes.

Beginning in 2015, the Board recognized the need to track deaths of children that take place at the residence of the child when that residence is being used as a licensed or unlicensed child care home for other children. Since 2015, there has been one death that met these criteria.

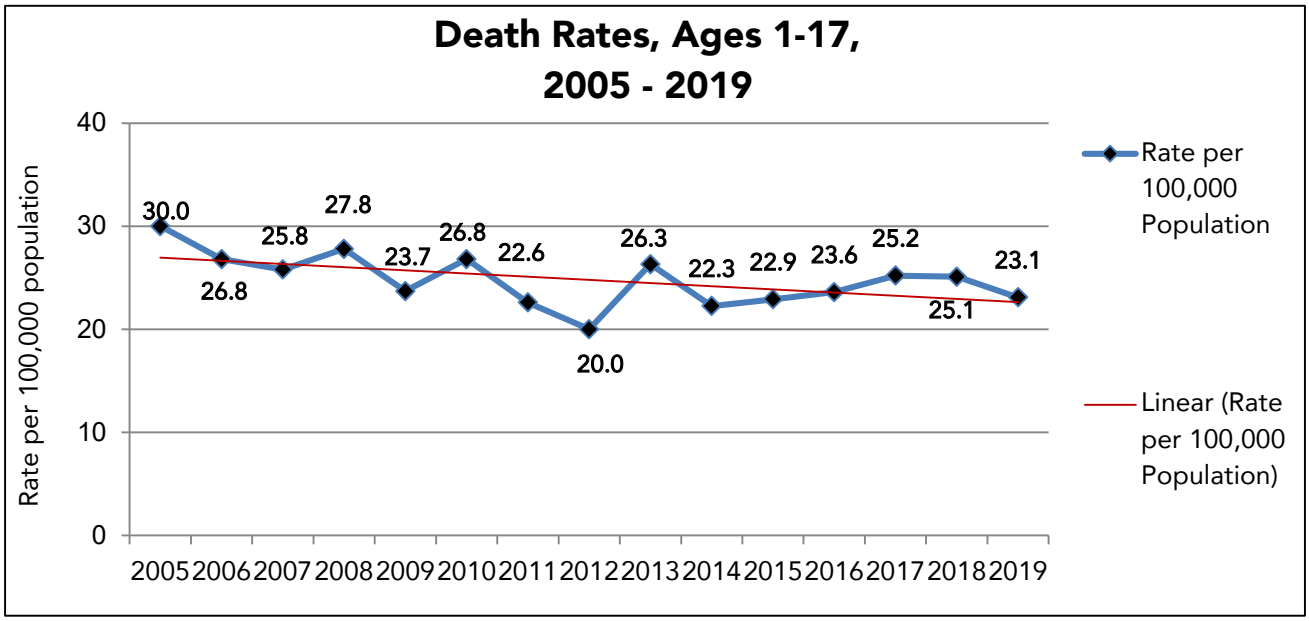
PREVENTION POINTS FOR PARENTS WHEN SELECTING CHILD CARE HOMES AND CENTERS

- Child care homes and centers must be licensed by KDHE. Parents should ask to see the license or certificate – it documents the license type and maximum number of children allowed to be enrolled in that home or center.
- The compliance history of a child care facility in Kansas can be accessed by calling the Kansas Department of Health and Environment Child Care Licensing Program at (785) 296-1270 or visiting https://www.kdheks.gov/bcclr/capp.htm
- Child care providers should develop a safe sleep policy that is discussed with parents.
- Child care providers and parents should communicate frequently to assure they understand safe sleep and that these practices are followed at home and in child care. Safe sleep recommendations are listed with the Sleep-Related Deaths prevention points on page 18.

Mortality Affecting Children Ages 1-17

The mortality rate for children ages 1-17 has remained relatively unchanged. However, the linear rate per 100,000 population over the past 15 years has continued to decline (Figure 23). There were 159 deaths in this age group in 2019.

Figure 23



Figures 24 and 25 show relative percentages of death by non-natural causes in this age group for the five previous reporting years as compared to 2019. Unintentional Injury-MVC represents the largest percentage of non-natural deaths for the previous five reporting years. However, in 2019 the number of suicides outnumbered motor vehicle crash deaths for children age 1-17. The number of suicides for 2019 represents 27% of deaths compared to 24% over the previous five years.

Figure 24

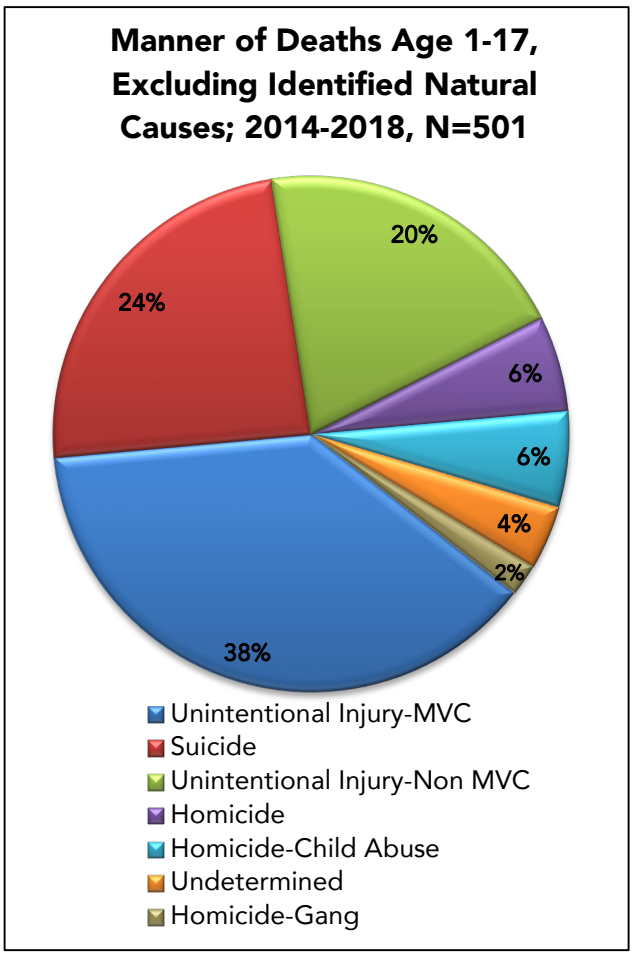


Figure 25

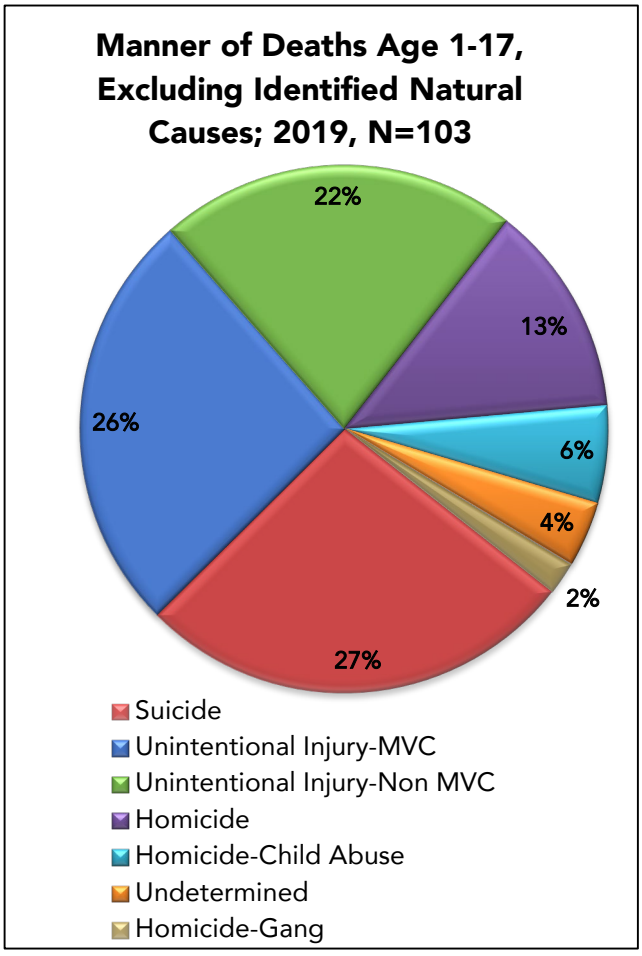


Figure 26 shows the number of unintentional injuries by age classification for the most recent 5 years of reviews. When looking at the 1-17 age group, motor vehicle crashes (MVC) and other transport-related deaths claimed the lives of 183 children and teens and was the primary cause of Unintentional Injury deaths in all age groups except infants. The second-leading cause of Unintentional Injury deaths for the 1-17 age group was drowning, with 39 deaths for this timeframe. Of the 19 Unintentional Injury deaths due to Fire, Burn, and Electrocution for this period, one death was due to electrocution and the other 18 the result of fires/burns.

Figure 26

Unintentional Injury By Cause and Age Classification Age 0-17, 2015-2019 N=372					
	Age <1	**Age 1-4**	**Age 5-9**	**Age 10-14**	**Age 15-17**
MVC and Other Transport	8	26	35	42	80
Asphyxia	64	11	3	1	0
Drowning	1	15	4	9	11
Fire, Burn, Electrocution	1	10	6	1	1
Weapon, Including Body Part	0	4	2	2	4
Poisoning, Overdose or Acute Intoxication	0	1	1	0	8
Undetermined	0	0	0	0	1
Fall or Crush	1	1	3	0	2
Animal Bite or Attack	0	1	0	0	0
Exposure	1	2	0	0	0
Other Causes	3	0	0	1	2

Unintentional Injury deaths due to weapon use accounted for 12 deaths between 2015 and 2019. Weapon, as defined for board review, includes guns, knives, or other objects, including body parts. Guns should be stored unloaded in a locked location out of a child's reach and sight. Leaving guns where they are accessible to children, such as in or on dressers or nightstands, can lead to injury or death.

It should not go unnoticed that the third leading cause of unintentional injury death for teens aged 15-17 was poisoning, overdose, or acute intoxication. The environment in which our youth are raised influences whether they will try drugs or other substances. At home, school and in the community, caregivers and school educators should address the dangers of drugs and alcohol and the risk of lethality from misuse or abuse. The Centers for Disease Control and Prevention (CDC) measures the prevalence of risk behaviors for students in grades 9-12 through the national Youth Risk Behavior Surveillance System (YRBSS). YRBSS monitors six categories of priority health-risk behaviors among youth and young adults. One of those categories is Alcohol and Other Drug Use. In 2019, 16.2% of the youth in Kansas reported having taken "prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it." More information regarding this data can be found at: https://www.cdc.gov/healthyyouth/data/yrbs/index.htm.

OVERDOSE PREVENTION POINTS

Young people are at high risk of substance abuse. These steps may help prevent teens from using alcohol and abusing prescription medications.

- **Discuss the dangers and rules of taking medications.** Medications are prescribed by physicians for specific patients and specific purposes. The fact that they are prescribed does not make them safe for others. Children and teens should be instructed to never take medications that are not prescribed for them, never share their medications with any other person, and not combine medications without being instructed to by a pharmacist or physician.
- **Discuss the dangers of alcohol use.** Using alcohol with medications can increase the risk of accidental overdose.
- **Prescription medications should not be accessible to children.** Quantities of medications should be tracked and all medications kept in a locked cabinet.
- **The ability to order medications online is a risk factor for teens to access and use medications inappropriately.** Some websites sell counterfeit and dangerous drugs that may not require a prescription. Internet use should be monitored and parents should assure teens are not accessing drugs through friends or outside sources.
- **Properly dispose of medications.** Unused or expired drugs should be discarded. Patient information guides with the medication may provide disposal instructions, or pharmacies can be contacted for advice on disposal.

Source: http://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/basics/prevention/con-20032471

Unintentional Injury – Motor Vehicle Crash Deaths

In 2019, 30 children died in Kansas due to unintentional injuries sustained in Motor Vehicle Crashes (MVC). Figure 27 shows the MVC death rate has continued to decline with 2019 having the lowest rate (4.3 deaths per 100,000 population) since the inception of the Board.

Figure 27

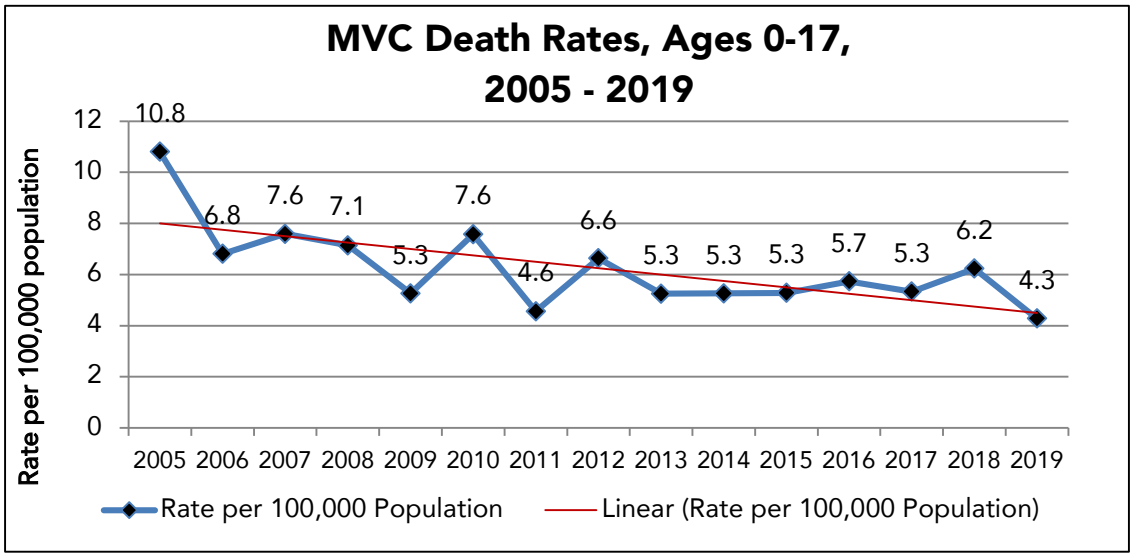


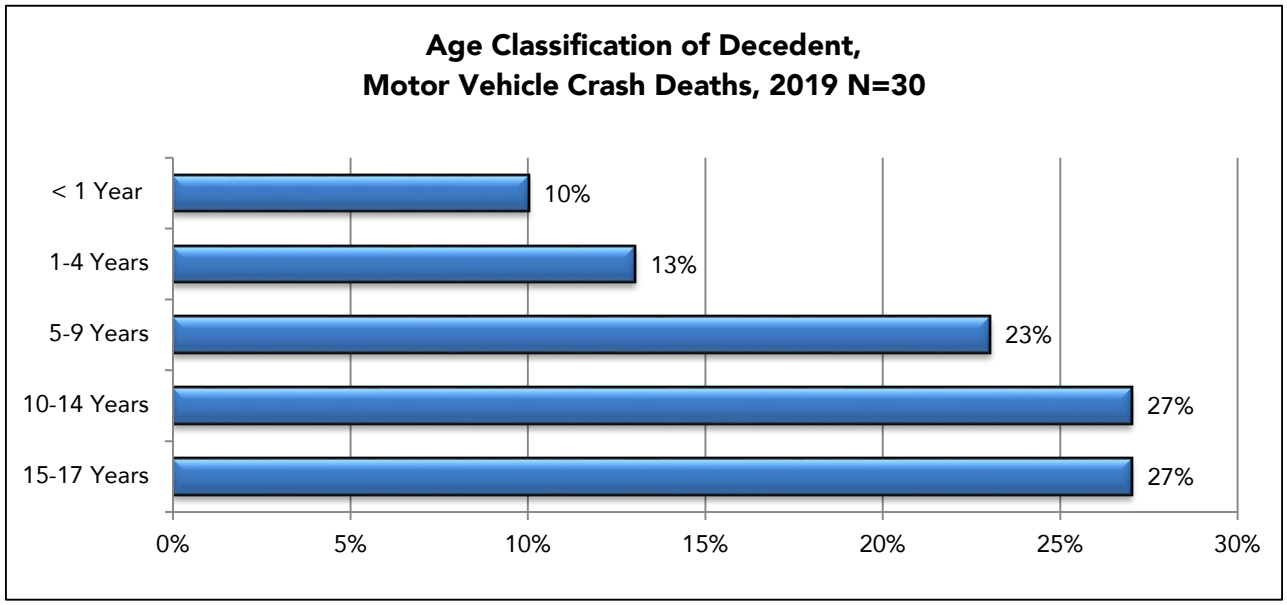
Figure 28

Motor Vehicle Death Rates per 100,000 Population, Ages 0-17, by Age Group, 2005-2019					
	< 1 Year	Age 1-4	Age 5-9	Age 10-14	Age 15-17
2005	2.0	4.0	8.3	6.4	34.5
2006	3.0	2.6	2.1	7.3	18.9
2007	3.0	5.1	1.1	6.9	23.2
2008	0.0	5.6	2.1	6.9	21.2
2009	4.0	4.3	1.0	1.6	18.9
2010	0.0	6.1	5.9	3.0	22.5
2011	2.5	4.9	3.5	3.5	8.4
2012	2.5	4.3	3.9	6.5	16.1
2013	2.8	2.5	2.9	4.5	15.2
2014	5.0	2.5	3.9	4.0	13.5
2015	2.6	2.5	5.4	3.0	13.3
2016	7.9	2.6	4.5	5.0	12.5
2017	0.0	3.9	3.0	5.0	13.4
2018	2.7	5.2	1.0	4.0	21.1
2019	8.5	2.7	3.6	4.0	6.7
Average	**3.1**	**3.9**	**3.5**	**4.8**	**17.3**

In general, the likelihood of a child dying due to a motor vehicle crash increases as the child becomes older (Figures 28 and 29). Teens in the 15-17 age group typically account for the highest percentage of MVC deaths each year, however in 2019, experienced a much lower rate of death compared to previous years (Figure 28).

Of the 30 Motor Vehicle Deaths in 2019, 24 of the children were either the driver or a passenger of the vehicle. An additional five children were pedestrians and one child was riding a bike.

Figure 29



It is important to note that there are multiple factors that can lead to a MVC death. Combined data for 2015-2019 includes 191 MVC fatalities. Of those fatalities, there were 454 combined factors that were reported as having contributed to those deaths. A list of those factors can be found in Figure 30.

Speeding, whether over the limit or unsafe for the conditions, was a contributing factor in 54% of the MVC deaths in 2015-2019. Driver inexperience accounted for another 33% of the MVC deaths. While 17% (32) of the MVC deaths during these five years had a contributing factor of alcohol or drug use, in eight of these crashes, it was the underage decedent operating the vehicle while under the influence.

Figure 30

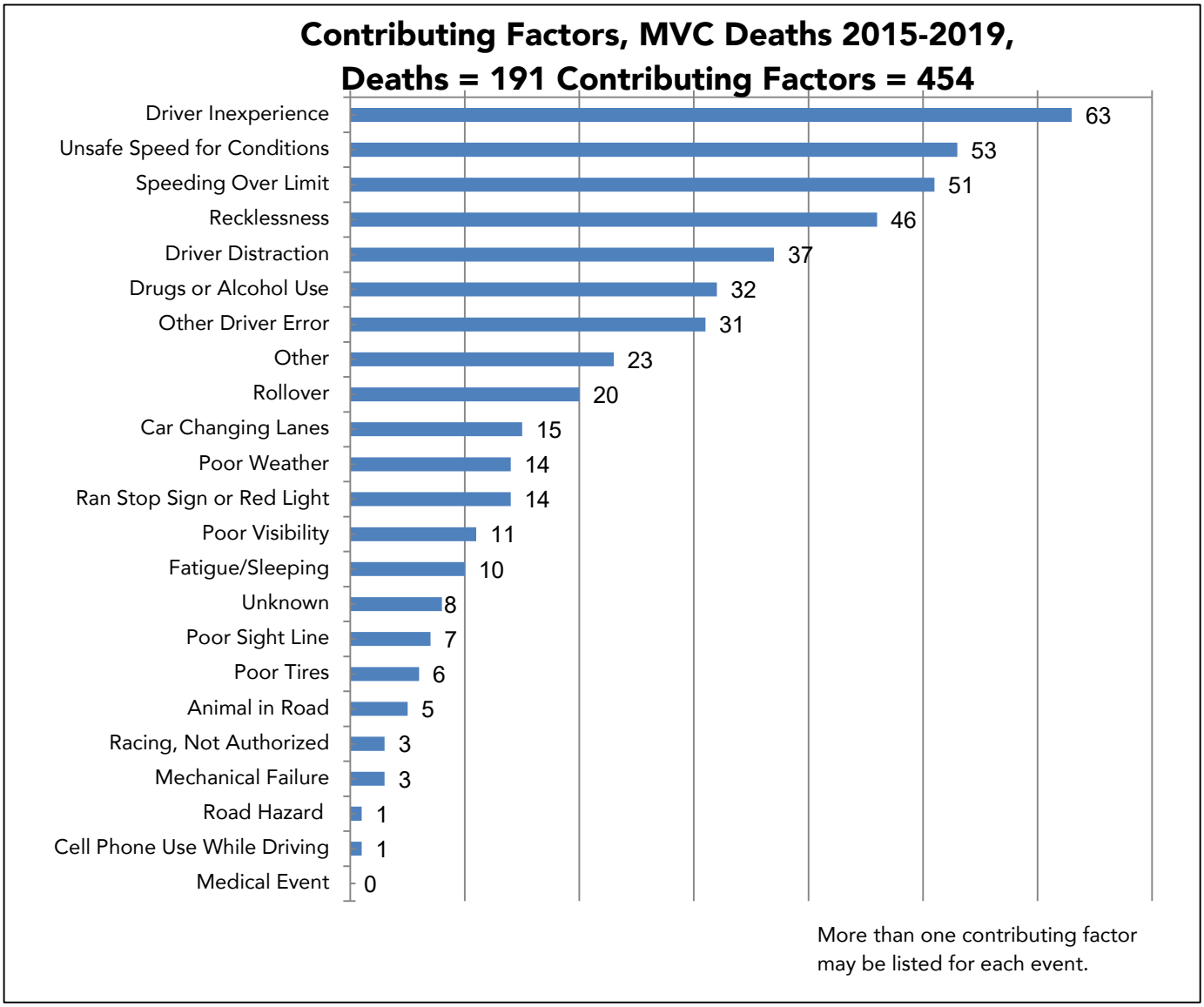

Contributing Factors, MVC Deaths 2015-2019,
Deaths = 191 Contributing Factors = 454
Driver Inexperience 63
Unsafe Speed for Conditions 53
Speeding Over Limit 51
Recklessness 46
Driver Distraction 37
Drugs or Alcohol Use 32
Other Driver Error 31
Other 23
Rollover 20
Car Changing Lanes 15
Poor Weather 14
Ran Stop Sign or Red Light 14
Poor Visibility 11
Fatigue/Sleeping 10
Unknown 8
Poor Sight Line 7
Poor Tires 6
Animal in Road 5
Racing, Not Authorized 3
Mechanical Failure 3
Road Hazard 1
Cell Phone Use While Driving 1
Medical Event 0
More than one contributing factor may be listed for each event.

Figure 31 breaks down the contributing factors by whether the decedent was a pedestrian or where the decedent was in the car at the time of the crash. Driver inexperience was the lead contributing factor for driver deaths, and unsafe speed for conditions was the lead contributing factor for passenger deaths. While it is suspected that cell phone use is a contributing factor in many of the child fatalities reviewed by the Board, in only one death was there adequate evidence to implicate "cellphone use while driving" as a contributing factor in the crash. In order to address prevention factors, it is important for the Board to have thorough and accurate investigations and documentation of contributing factors, such as cell phone or drug/alcohol use.

Figure 31

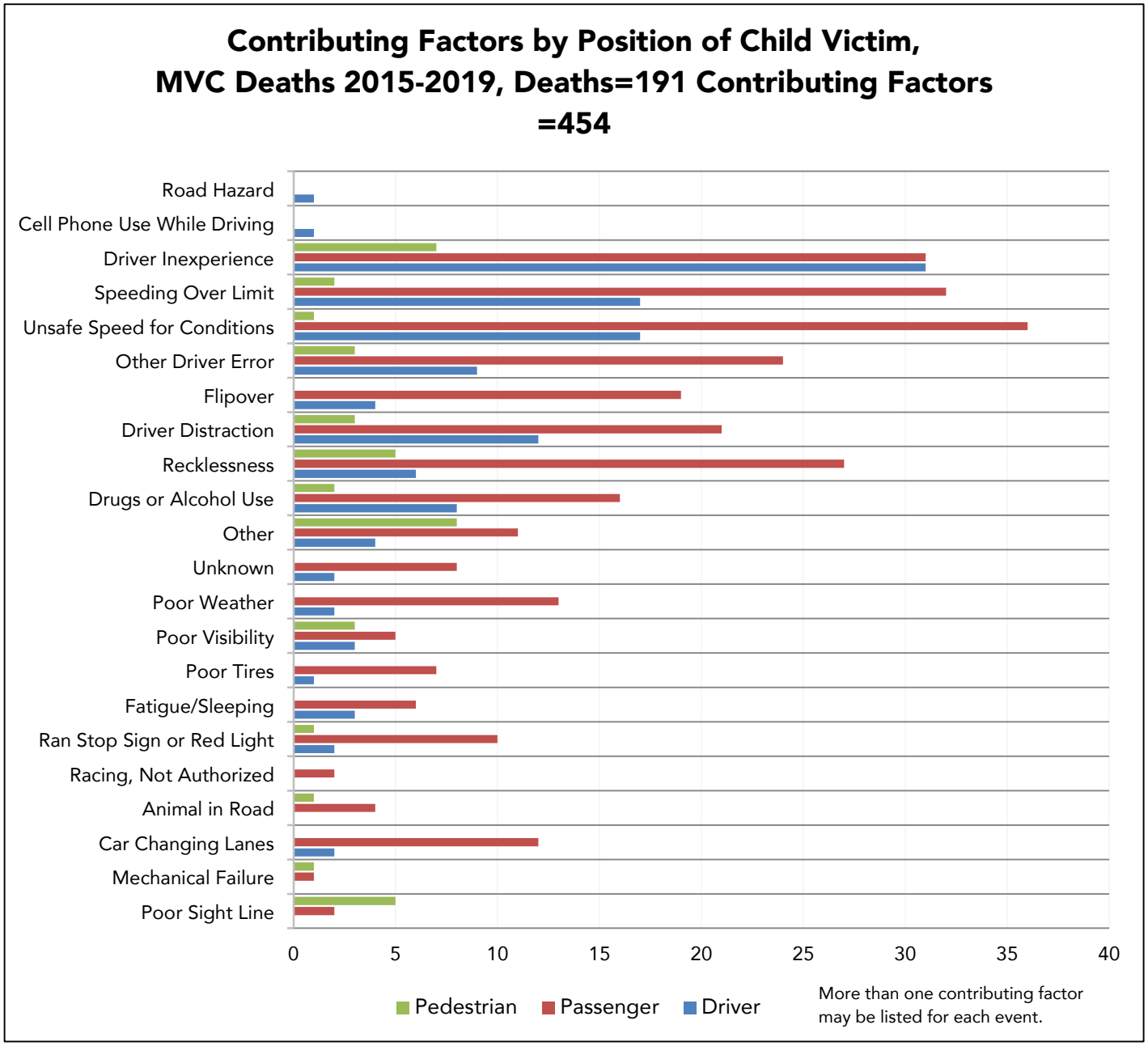


Figure 32 displays the type of safety restraint used based on the location of the victim in the vehicle. Between the years of 2015 and 2019 there were 165 deaths of children due to MVCs. Of those deaths, 32% (52) of the decedents were the driver of a motor vehicle at the time of their death with only 35% (18) being properly restrained at the time of the crash. In total, when looking at safety restraint use, 52% of the decedents were either incorrectly restrained or unrestrained for all locations in the vehicle. Figure 32 does not include in the total the 26 pedestrian deaths.

Figure 32

Safety Restraint Use by Decedent, 2015-2019 N=165					
	Driver	**Passenger Front Seat**	**Passenger Back Seat**	**Passenger Other***	**Total**
Restrained	18	9	28	1	56
Restrained, Incorrectly	0	3	3	0	6
Unrestrained	25	18	32	4	79
Unknown if Restrained	6	6	1	3	16
Other**	3	1	0	4	8
Total	52	37	64	12	165

*Passenger Other is often used to categorize passengers on motorcycles, planes, farm equipment, or when the decedent was in-utero at the time of the crash.

**Other is often used to categorize situations in which the decedent was in transport vehicles that did not have a typical restraint system. For example a motorcycles, airplane, tractor, etc.

Kansas experienced 14 child deaths from All Terrain Vehicle (ATV) crashes in the five-year period from 2015 and 2019. According to the 2020 Annual Report of ATV-Related Death and Injuries published by the U.S. Consumer Product Safety Commission, in 2019, there were an estimated 96,000 ATV-related, emergency department-treated injuries in the United States. An estimated 27% of these involved children younger than 16 years of age.

ATV use is popular in both recreation and agriculture work. This type of vehicle size, maneuverability and durability makes it extremely versatile and fun to ride. Drivers of ATVs often use roadways not designed for ATV travel and often drive at unsafe speeds.

Since the board began reviewing child deaths in 1994, the largest number of ATV-related child fatalities has been in the 10-14 year age range. In 2019, one child died in an ATV crash. Young riders lack the size and strength to safely control an ATV. Operating or riding in an ATV carries a substantial risk of serious injury or death. Due to the risk associated with operating ATVs, laws requiring a minimum operator age of at least 16 should be considered as a way to prevent future ATV-related

deaths in children. At a minimum, all ATV users should wear a helmet, eye protection, and protective clothing, and use appropriate restraints when riding in or operating an ATV.

Characteristics of the 30 Motor Vehicle Crash Deaths, 2019

- 23 decedents were male; 7 were female.
- 2 of the decedents were driving a vehicle at the time of their demise.
  - Both were unrestrained males.
- 6 decedents were pedestrians.
  - 2 were riding a bike or skateboard, 4 were walking.

"Bucks for Buckles," an initiative of Safe Kids Kansas, State Farm, and the Kansas Department of Transportation is one example of how agencies in our state are collaborating to educate the public about the importance of seat belts. Typically, in late summer, volunteers in multiple cities statewide hand out one-dollar bills to drivers who have all occupants buckled up and secured in their vehicles. Drivers with unrestrained passengers get educational materials about the effectiveness of seat belts and child safety seats. Due to safety concerns related to COVID-19, the Bucks for Buckles initiative was suspended for 2020 and early 2021. Alternate ways to engage youth on the importance of seat belt usage are being explored. Safe Kids Kansas provides helpful information regarding child passenger safety on their website at: http://www.safekidskansas.org/.

PREVENTION POINTS

- **Use of Proper Safety Restraints** – Wear seat belts. Seat belts and appropriate child safety restraints consistently prevent serious injury and death. According to the National Highway Traffic Safety Administration, parents who buckle up are more likely to use safety restraints for their children. Children under 4 years of age should be placed in a child safety seat firmly secured in the backseat. Children between the ages of four and eight should be in belt-positioning booster seats in the back seat. Parental seatbelt use as an example to children and passengers is invaluable.
- **Attentive Driving** – Avoid distractions such as cell phones and other electronic devices. Novice drivers should have limits placed on the number of passengers and nighttime driving, which are known risk factors.
- **Avoiding Alcohol or Drug Use** – It is never safe to drive after drinking alcohol or using narcotics or other mood-altering drugs. Avoid riding with anyone who is suspected of being under the influence of drugs or alcohol.
- **Driving Experience** – Driving is not a quickly learned skill and requires practice, focus and good judgment. Young drivers should be accompanied by an experienced adult and avoid complex driving situations. In January 2010, the revised graduated driver's license system was enacted and does not confer full driving privileges until age 17 and after significant supervised driving time.
- **Stay Alert-** Pedestrians need to be visible to drivers at all times and stay in well-lit areas, especially when crossing the street. While distractions such as cell phones and headphones are a daily part of youth's lives, they are dangerous to pedestrians who are looking down or unable to hear what is going on in their surroundings.

CASE VIGNETTE

TEEN DEATH DUE TO MOTOR VEHICLE CRASH

Seat belts save lives – A vehicle with multiple teen occupants was involved in a single vehicle rollover crash. Although injured, the appropriately restrained passengers of the vehicle survived while the unrestrained driver died at the scene.

Board Reflection – Parents and caregivers should require seat belt use long before their children are able to drive or ride in vehicles with others. One way to reinforce the habit is for caregivers to belt themselves and insist that occupants in the car do so as well.

CASE VIGNETTE

TEEN DEATH DUE TO MOTOR VEHICLE CRASH

Alcohol and drug use while driving can be fatal – A teen who died from injuries sustained in a motor vehicle crash was found at autopsy to have consumed a sufficient amount of alcohol to be intoxicated. Reports indicated that the decedent, driver, and other passengers of the vehicle were all teens who had recently left a party where alcohol was provided to minors.

Board Reflection – In recent years, several preventable motor vehicle fatalities included teen drivers who were under the influence of alcohol or drugs at the time of the crash. The Board feels it is critical for MVC investigations to identify the source of the illegal alcohol or other substances associated with the MVC. Minimum legal drinking age and zero tolerance laws in every state make it illegal to sell alcohol to anyone under age 21 and for those under age 21 to drive after drinking any alcohol. Research has shown that enforcement of these laws and using alcohol retailer compliance checks have reduced drinking and driving crashes involving teens. Parental involvement, with a focus on monitoring and restricting what teen drivers are allowed to do, helps keep teens safe as they learn to drive. Parents should consider a parent-teen driving contract with their teens, including consequences for noncompliance. More information about teen drinking and driving can be found at: https://www.cdc.gov/vitalsigns/teendrinkinganddriving/.

Unintentional Injury – Drowning Deaths

In 2019, seven children died from unintentional drowning. Children are drawn to water. They like to splash and play in it, but this lure is deceptive and can lead to tragedy. Children can drown in minutes and in only a few inches of water. Between 2005 and 2019, there were 135 unintentional drowning deaths. Figure 33 shows drowning death rates for all ages 0-17 combined over the last 15 years. Since 2005, the 1-4 year age group, on average, has accounted for the highest rate of deaths when compared to the other age groups (Figure 34).

Figure 33

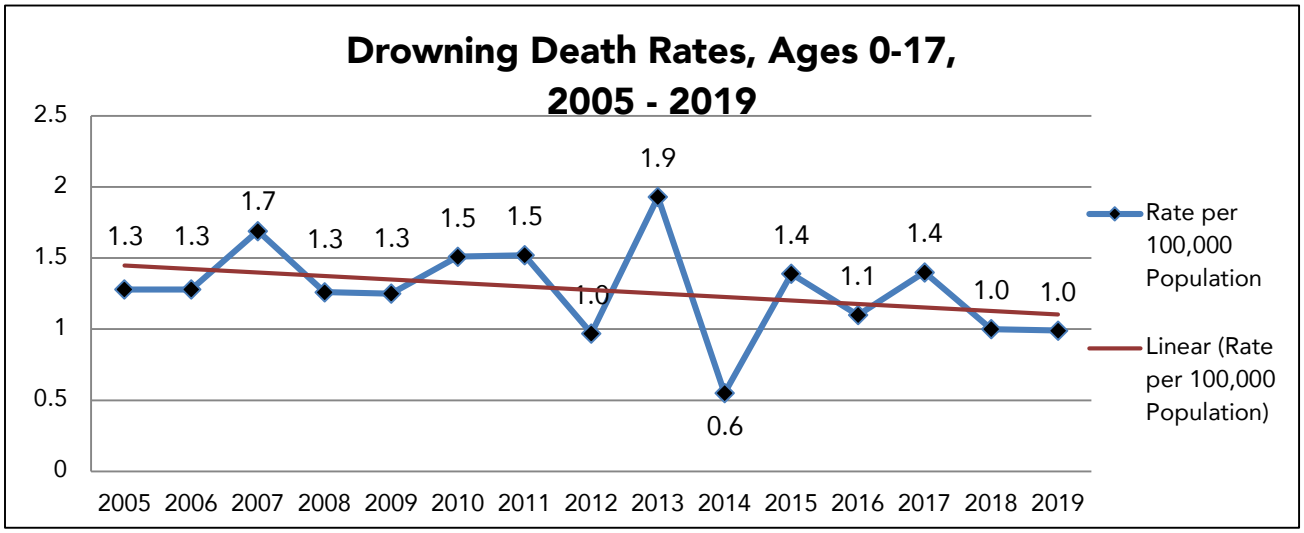
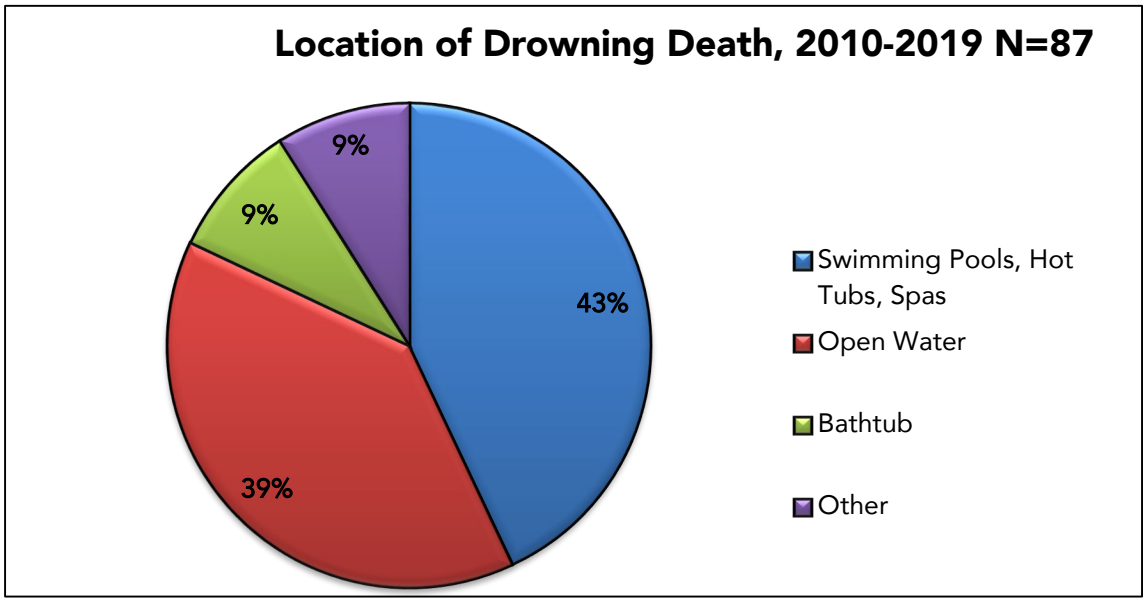


Figure 34

Drowning Death Rates per 100,000 population, Ages 0-17, by Age Group, 2005-2019					
	< 1 Year	**Age 1-4**	**Age 5-9**	**Age 10-14**	**Age 15-17**
2005	0.0	5.4	0.0	0.5	0.0
2006	1.0	2.6	0.5	0.0	2.0
2007	2.0	3.2	0.5	1.6	0.8
2008	0.0	4.4	0.5	0.0	0.8
2009	0.0	3.1	0.5	1.1	0.9
2010	0.0	3.6	1.5	1.0	0.0
2011	0.1	0.4	0.6	0.1	0.3
2012	0.0	2.4	1.0	0.5	0.0
2013	0.0	3.1	0.5	2.5	4.2
2014	0.0	1.9	0.0	0.0	0.8
2015	0.0	3.2	0.5	1.5	0.8
2016	0.0	1.3	0.0	0.5	2.5
2017	2.6	1.9	1.0	1.5	0.8
2018	0.0	2.0	0.5	0.5	1.7
2019	0.0	1.3	0.0	1.0	3.4
Average	**0.4**	**2.7**	**0.5**	**0.8**	**1.3**

As shown in Figure 35, swimming pools and open water have been the primary location of child drownings in the last 10 years. Proper supervision and floatation devices for children of all ages are very important. Children are not only at risk during the summer when pools are mainly in use, but also when they are not in use and still accessible. Four-sided fencing of swimming pools, including soft-sided pools, on residential properties is an additional and necessary tool to prevent drownings. Many of the same prevention points can be applied to swimming in locations of open water. Open water, which includes rivers, lakes, and ponds, are popular areas for Kansas children to visit. Despite the ability to swim, swimming in open water is more challenging than in a pool. Children and youth can tire quickly and if they go under water, the murky water and currents can make it difficult for even the best swimmer to be seen and rescued.

Figure 35



The use of personal floatation devices is essential for children of any age despite their ability to swim. In 2019, none of the children who died due to unintentional drowning were wearing a floatation device.

Because drownings can occur in only a few minutes and with only a few inches of water present, young children can become vulnerable to drowning in locations that most caregivers would not see as a threat. Figure 35 shows that in 9% of the drowning deaths, the location of the drowning was listed as "other". Toilets, buckets of water, washing machines, large puddles, etc. are all "other" locations that small children could encounter within their own home and that without proper supervision could endanger them. In 5 of the 7 unintentional drowning deaths in 2019, poor or absent supervision was noted to be either the direct or contributing factor. Every minute counts in drowning situations. Proper supervision and appropriate personal floatation devices are critical prevention measures when children are near water.

CASE VIGNETTE

CHILD DEATH DUE TO DROWNING

Proper Supervision is critical with small children – During a family gathering with several adults present, a toddler was able to stray from the area of adult supervision. The child was missing for only a few minutes before being found unresponsive in a nearby pool.

Board Reflection – Drownings can occur in just inches of water and within a few minutes. Without proper supervision, everyday items that contain water such as washing machines, bathtubs, buckets, and outside pools can be fatal for a child who falls in. Safety-proofing homes as well as proper supervision of small children is essential to preventing unintentional injuries and drownings.

PREVENTION POINTS

- **Home Safety-** Small children can drown after falling into buckets, toilets, washing machines or other containers holding water. In bathtubs, children can drown in only a few inches of water and seats designed to hold a baby's head above water are no substitution for adult supervision. Caregivers must be vigilant about these less obvious dangers and ensure that in addition to adequate supervision, creating barriers to areas or items in the home where water is accessible may be needed. Ways to prevent drowning deaths inside the home include keeping bathroom doors closed, adding locks to toilets, and ensuring buckets, coolers, and other containers are not stored with water.
- **Proper Supervision** – An adult capable of responding to an emergency should always supervise children around water. The adult should actively watch and avoid distractions. Assigning swim "buddies" is recommended, especially if there are many swimmers. Supervision also applies to other areas in the home including bathtubs, where children should never be left alone even for brief periods.
- **Pool Environment Safety** – Most cities/counties have ordinances regarding fencing around pools. A 5-foot fence with safety-latched gates completely encircling a pool or hot tub is recommended.
- **Use of Safety Equipment** – When participating in water activities, children should always wear Personal Floatation Devices (PFDs) that are Coast Guard approved and suited for the proper weight of the child. PFDs should be checked for broken zippers and buckles. "Water wings" and other inflatable items are not adequate substitutes.
- **Water Safety Education** – Children should have swimming lessons and water safety education. The American Academy of Pediatrics recommends waiting until age 4 to begin lessons. While this is vital, swimming ability alone does not relieve the need for adult supervision and PFDs.
- **Water conditions** – Lakes, ponds and ditches often contain murky water and tangled branches or other items that pose a potential danger to swimmers. Research these areas and become familiar with possible dangers such as large rocks and underwater currents. Know water depth and underwater hazards before allowing children to jump into any body of water. It is also advised to check local weather conditions prior to swimming or boating, as thunderstorms with lightning or strong winds could be fatal. Parents and caregivers should educate children about the dangers of going out onto a frozen body of water for recreational purposes such as ice skating or fishing.

Unintentional Injury – Fire, Burn and Electrocution

In 2019, three Kansas children died in unintentional fire, burn and electrocution incidents. Figures 36 and 37 indicate death rates in this category for all children and by age group per 100,000 population for the past 15 years in Kansas.

Figure 36

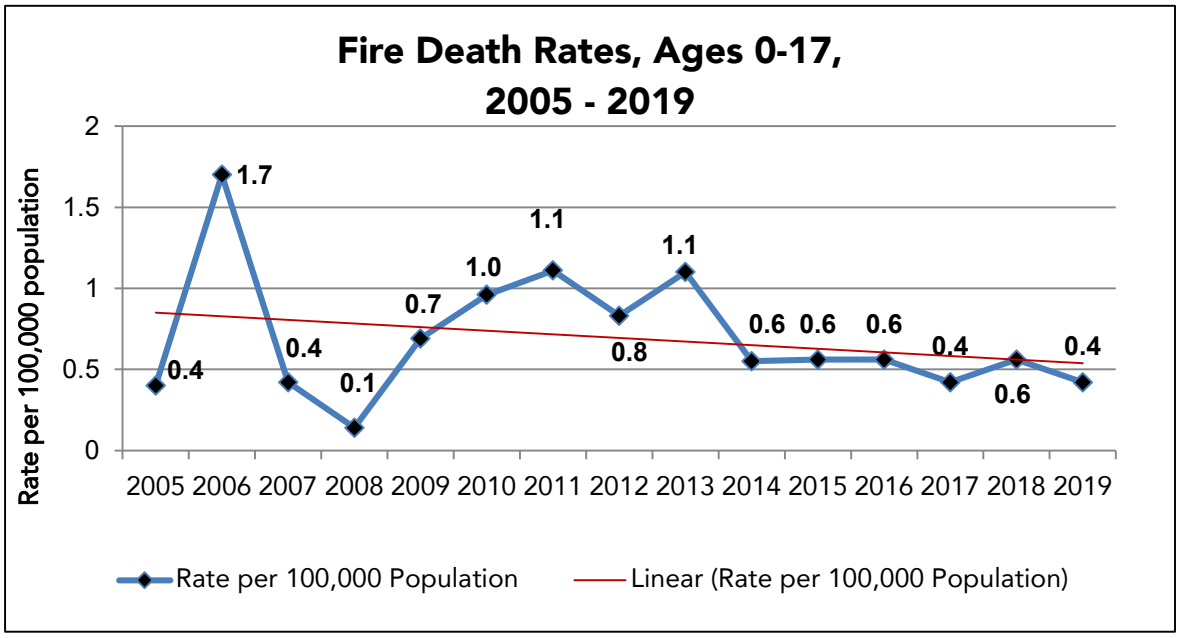


Figure 37

Fire Death Rates per 100,000 population, Ages 0-17, by Age Group, 2005-2019					
	< 1 Year	**Ages 1-4**	**Ages 5-9**	**Ages 10-14**	**Ages 15-17**
2019	0.0	0.7	1.0	0.0	0.0
Average 2005-2019	**0.7**	**1.5**	**0.8**	**0.3**	**0.3**

All three fire-related deaths in 2019 occurred in homes that did not have working smoke alarms present. Parents and caregivers must be diligent about having functional smoke alarms in all appropriate locations in the home. Smoke alarms need to be installed on every level in the home and by each sleeping area. They should be tested once a month, have new batteries at least once a year, and be replaced every 10 years. Close supervision of children, safe storage of matches and lighters, and working smoke alarms in the home are critical.

Fire is often started by children playing with matches or lighters. It is vital for parents and caregivers to keep all lighters, matches, and other igniting sources out of reach of children. They also need to educate children on the dangers of fire and practice escape routes in the event a fire does occur.

PREVENTION POINTS

- **Proper Supervision** – Young children must be watched closely. Leaving them unsupervised, especially if there are objects such as candles, lighters or matches within their reach, could result in a serious injury or death.
- **Prevent Access to Fire-Starting Material** – Matches, lighters, candles, etc. should be kept away from children. Do not assume a young child cannot operate a lighter or match.
- **Working Smoke Alarms** – Smoke alarms should be placed inside and outside of each sleeping area and on every level of the house, including the basement. Smoke alarms should be tested once a month to ensure they are working.
- **Emergency Fire Plan** – Everyone in the house, including the children, should know all exits from the house in case of a fire. Ensure that gates or unnecessary clutter do not block exits. Designate a central meeting location outside of the home and have regular fire drills.

Unintentional Injury - Agriculture Related Deaths

The most recent census data from 2017 indicates there are likely more than 58,000 farms in Kansas, most of which are family owned. Unlike other industries, the farm includes an intermingling of home and worksite activities for Kansas families. As a result, children can be exposed to agricultural hazards that lead to unintentional injury and fatalities.

In the last five years, Kansas has experienced eight agriculture-related deaths of children. A majority of agriculture-related child deaths in Kansas within the last five years involved a motor vehicle such as a tractor, ATV, or other heavy machinery. While lack of supervision was a primary risk factor in many of these fatalities, failing farm equipment or equipment void of safety features also contributed to several of the deaths.

Kansas Farm Bureau provides education materials for all ages specific to agriculture and farm safety. In addition, Kansas Farm Bureau sponsors a safety poster program offered to students in Kansas (grades 1-6). This injury prevention program, available since 1950, is an effort to develop "safety-minded" youth. Educational materials and contest winners are accessible at https://www.kfb.org/.

Prevention Points

- **Proper Supervision** – Parents and caregivers should not engage in farm work while supervising young children at the same time. As children learn how to assist with farm related tasks, supervision and guidance is critical to their safety until they are able to demonstrate the ability to safely perform tasks appropriate for their age and development.
- **Safety Around Power Take-Off (PTO)** – Many injuries and fatalities have been a result of entanglement in PTOs. Safety shields should be in place and in good working condition. Furthermore, children should be reminded to never step or jump over a PTO as clothing can become entangled in the moving parts. PTO's should be disengaged when idle or not in use.
- **Equipment Safety** – Children should not operate machinery such as lawn mowers, tractors, or ATVs until they are trained to safely do so. Steps should be taken to ensure that riders and drivers of ATVs and other farm equipment use helmets and protective gear.
- **Safe Play Area** – Children should have a safe place to play where they are supervised and protected from potential hazards of farm life. The area should be away from roadways and areas where equipment is operated.

Asthma

In the last 10 years of SCDRB cases (2010-2019) there have been 23 child deaths due to asthma, three of which occurred in 2019. These deaths occurred in children from ages 1-14 with the majority of deaths occurring to children in the 10-14 age group. Although the number of deaths is small, even one death is too many since asthma is a treatable disease.

The numbers and rates of pediatric asthma hospitalizations are one indication of how well a state overall is managing asthma. If asthma is well controlled a child should rarely need to be hospitalized for the disease.

Figure 38

Numbers and Rates of Pediatric Asthma Hospitalizations* Kansas, 2010 - 2019		
Year	**Number**	**Rate**
2010	732	113.3
2011	700	108.5
2012	886	138.2
2013	600	93.5
2014	726	112.6
FFY 2015 **	554	86.2
2016 †	482	75.5
2017§	376	59.2
2018	425	67.4
2019	341	54.5

* Admissions with a principal diagnosis of asthma per 100,000 population, ages 2 through 17 years. Excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions

** Calendar year rate cannot be calculated due to presence of ICD9CM and ICD10CM diagnoses. Federal fiscal year used.

† Rate calculated using ICD10CM diagnoses. Due to the difference in the coding methods, 2016 rate cannot be compared to prior years.

§ This value was revised due to an updated methodology and better reflects the true rate of pediatric asthma hospitalizations.

Residence Data
Source data: Kansas Hospital Association
Calculated using Agency for Healthcare Research and Quality Pediatric Quality Indicator software. Prepared by:
Kansas Department of Health and Environment
Bureau of Epidemiology and Public Health Informatics
Created: July, 20 2021
Contact: KDHE.HealthStatistics@ks.gov

Asthma is a chronic disease that affects the airways in the lungs. It is characterized by inflammation that restricts the ability to move air out of the lungs and leads to episodes of wheezing, coughing, shortness of breath and chest tightness. Severe asthma can lead to complete closure of the airways and is life threatening. There is no cure for asthma. It can be controlled through quality medical care with a management plan that includes rescue inhalers, preventive medications and asthma education. This also includes the ability to recognize and avoid each child's specific triggers such as allergens, exercise, tobacco smoke, air pollution and infections. It is estimated that one in 11 children have asthma, which makes it a common problem. Because it is common, parents and care providers often fail to understand that asthma is not a one-size-fits-all disease and do not appreciate how life threatening it can be if not treated quickly and appropriately.

It is imperative that children have access to medical providers who can effectively manage and control asthma, provide ongoing education and monitoring, and work with families, child care facilities and schools to improve the lives of children with asthma and prevent asthma related deaths. Child care providers and school personnel, including coaches and trainers, must have appropriate asthma education and access to each child's asthma action plan and medications. Immediate access to medical providers who can provide direction in urgent situations is also important to those caring for children with asthma.

Efforts to improve asthma care and education are part of hospital quality improvement efforts across the state. Involving families and other care providers in education is also essential. Continued monitoring of Kansas asthma hospitalizations and deaths will help in our assessment of how well our state is caring for children with asthma.

PREVENTION POINTS

- **Assessment and Monitoring** – Asthma is highly variable over time. Periodic, scheduled monitoring by health care providers familiar with standardized and evidence-based care is essential, even if the patient and family feel the child is doing well.
- **Education** – Teaching and reinforcement of self-monitoring skills and devices, use of a written asthma action plan, correct use of medications and devices, and avoidance of asthma triggers in the environment are areas of knowledge to adapt and integrate into all points of a child's care.
- **Control of Environmental Factors and Comorbid Conditions** – Avoidance of cigarette smoke exposure, determining and reducing exposures to allergens, consideration of allergen immunotherapy if indicated, and management of obesity, gastroesophageal reflux, obstructive sleep apnea and infections (including annual use of influenza vaccine) are important steps in asthma control.
- **Medications** – Medications and delivery devices must meet the child's needs and circumstances. A stepwise approach with therapy adjustments based on the child's asthma control are outlined with evidence-based support in Guidelines for the Diagnosis and Management of Asthma published by the National Heart, Lung and Blood Institute of the National Institutes of Health. (http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-report)

CASE VIGNETTE

YOUTH DEATH RELATED TO COMPLICATIONS OF ASTHMA

Access to treatment and medication must be readily available – A Kansas youth, diagnosed with asthma many years prior, reported to a caregiver that they were having trouble breathing. Both caregivers involved were aware the child's condition was severe but neither took the child for emergency medical care. Instead, the caregivers continued to attempt treatments at home despite previously being instructed on when to seek additional medical care. Unable to breathe, the child became unconscious and 911 was called. Despite appropriate emergency response services, the child died from complications of asthma.

Asthma deaths are rare but are preventable with appropriate monitoring and intervention – This child was previously hospitalized multiple times for asthma exacerbations. DCF intakes were initiated due to concerns about the caregivers' poor compliance with medical care and frequent missed appointments. DCF services were provided in the home but once the case was closed there was inadequate monitoring of the child's well-being. Close communication between child welfare workers and medical providers about the status of the case and the child's disease process is critical to assure continued health and safety.

Board Reflection – Asthma deaths are preventable. Asthma is one of the most common chronic disorders and varies in severity among children and even from year to year for each child. Because the symptoms vary and are dependent on genetic and environmental factors, families may not understand that asthma can unexpectedly become life threatening. They must be educated to understand the need to have rescue medications available at all times and to keep prescriptions filled, even if they feel their child is doing well. Asthma action plans are prescribed by physicians and provide critical directions to parents and caregivers about appropriate assessment and treatment of asthma based on the severity of the symptoms. Had this child's caregiver followed the asthma action plan provided, the child would have been taken to the emergency department to receive medications for reversal of the asthmatic process long before the disease exacerbation became deadly.

Homicide

There were 23 Kansas child homicides in 2019. Figure 39 indicates rates per 100,000 population for the past 15 years.

Figure 39

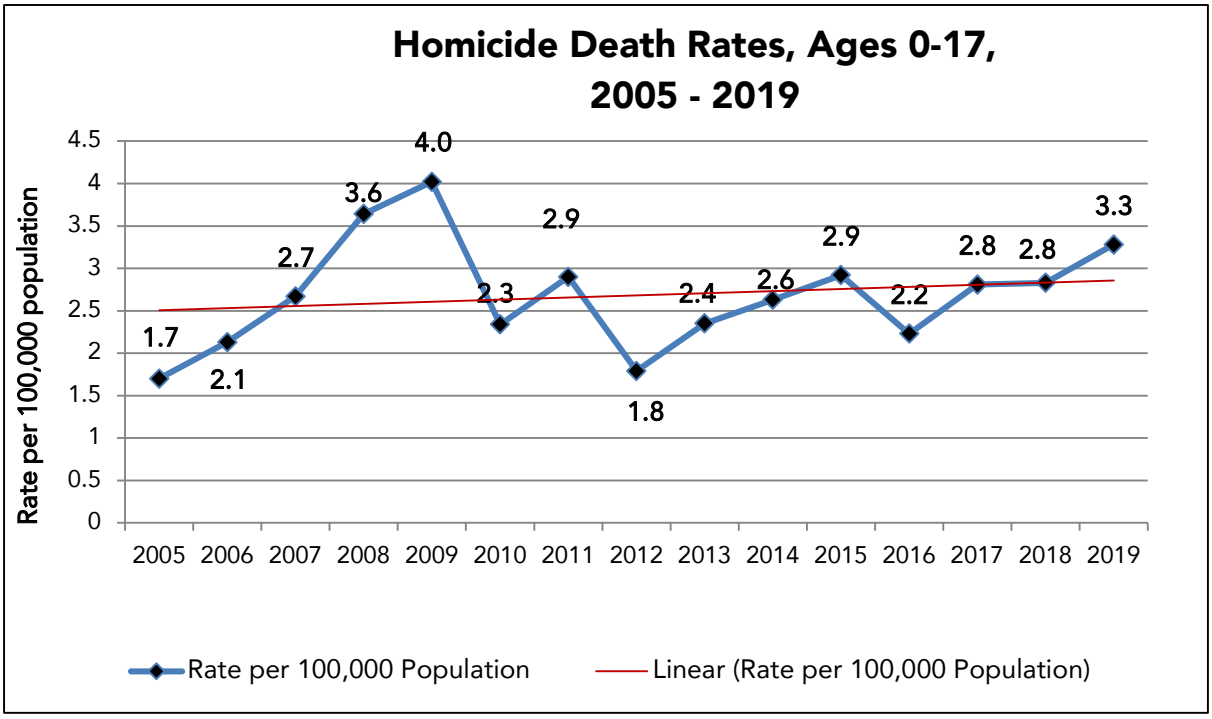


Figure 40 displays homicide rates per 100,000 population by age group. When examining child homicides, the average rate for infants is more than three times higher than other age groups. This difference is explained by the unique characteristics of the circumstances surrounding child abuse homicides, which account for nearly all infant homicides, and the vulnerability of very young children who are not capable of defending themselves against an assault, are small enough to pick up and shake, throw or strike, and whose crying and behavior can be frustrating to caregivers. These factors are discussed in more detail in the Homicide – Child Abuse section on page 45.

Figure 40

Homicide Death Rates per 100,000 population, Ages 0-17, by Age Group, 2005-2019					
	Age <1	**Age 1-4**	**Age 5-9**	**Age 10-14**	**Age 15-17**
2005	10.4	2.7	0.6	0.0	2.5
2006	7.6	0.6	1.6	1.6	4.1
2007	14.8	3.2	0.0	0.5	5.8
2008	16.5	5.6	0.0	0.0	8.5
2009	19.3	3.7	1.0	3.7	5.2
2010	9.8	3.6	0.5	1.5	2.5
2011	12.5	3.6	0.5	1.5	2.5
2012	7.5	1.8	1.0	0.0	4.2
2013	12.6	2.4	1.5	1.0	1.7
2014	15.0	3.1	1.0	2.0	1.7
2015	23.1	3.2	1.0	0.0	4.2
2016	13.1	2.6	1.0	0.5	3.3
2017	10.5	5.2	0.0	0.0	6.7
2018	10.9	3.3	1.5	0.0	6.7
2019	5.7	4.0	1.5	1.5	7.6
Average	**12.6**	**3.2**	**0.8**	**0.9**	**4.4**

Each child homicide is categorized into one of the following groups: Child Abuse Homicides, Gang Homicides, and Other Homicides (Figures 41 & 42). By categorizing homicides in this way, the Board is able to look in depth at specific issues pertaining to each category.

Of the total homicides in all categories for 2019 (Figure 42), 35% (8) were due to child abuse and 9% (2) were related to gang violence. The remaining 56% (13) did not meet the definition of gang violence or child abuse.

Figure 41

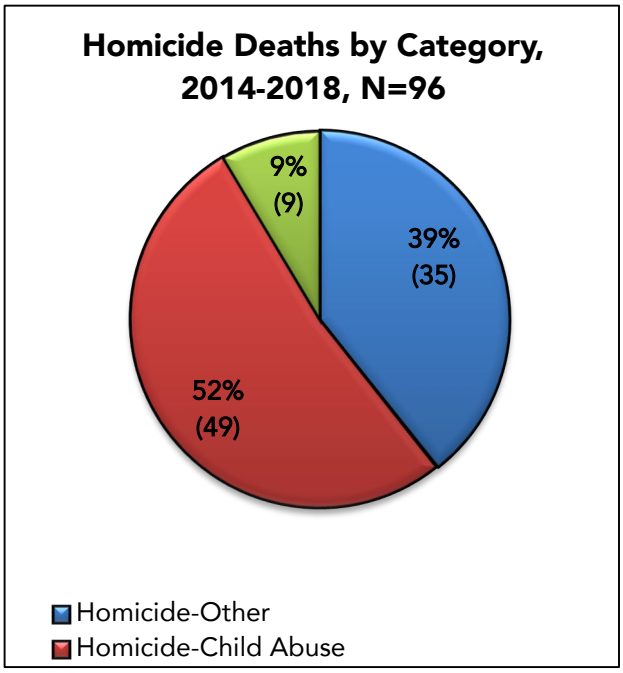
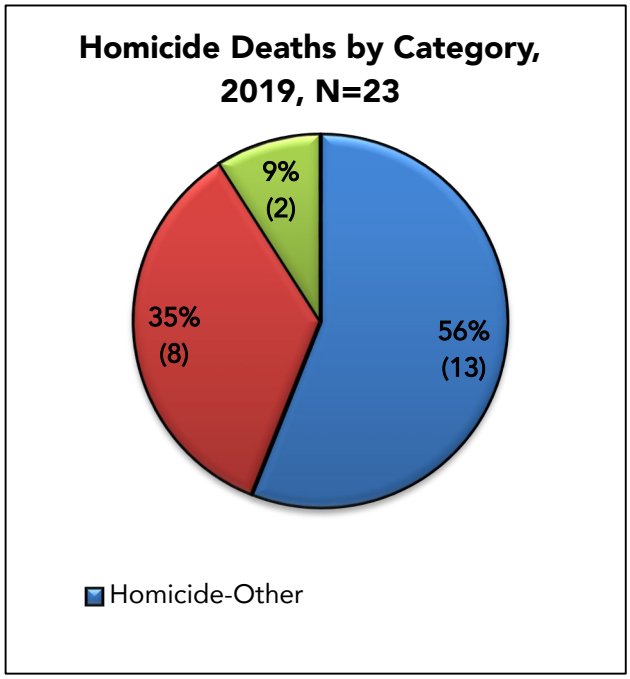


Figure 42



HOMICIDE – CHILD ABUSE

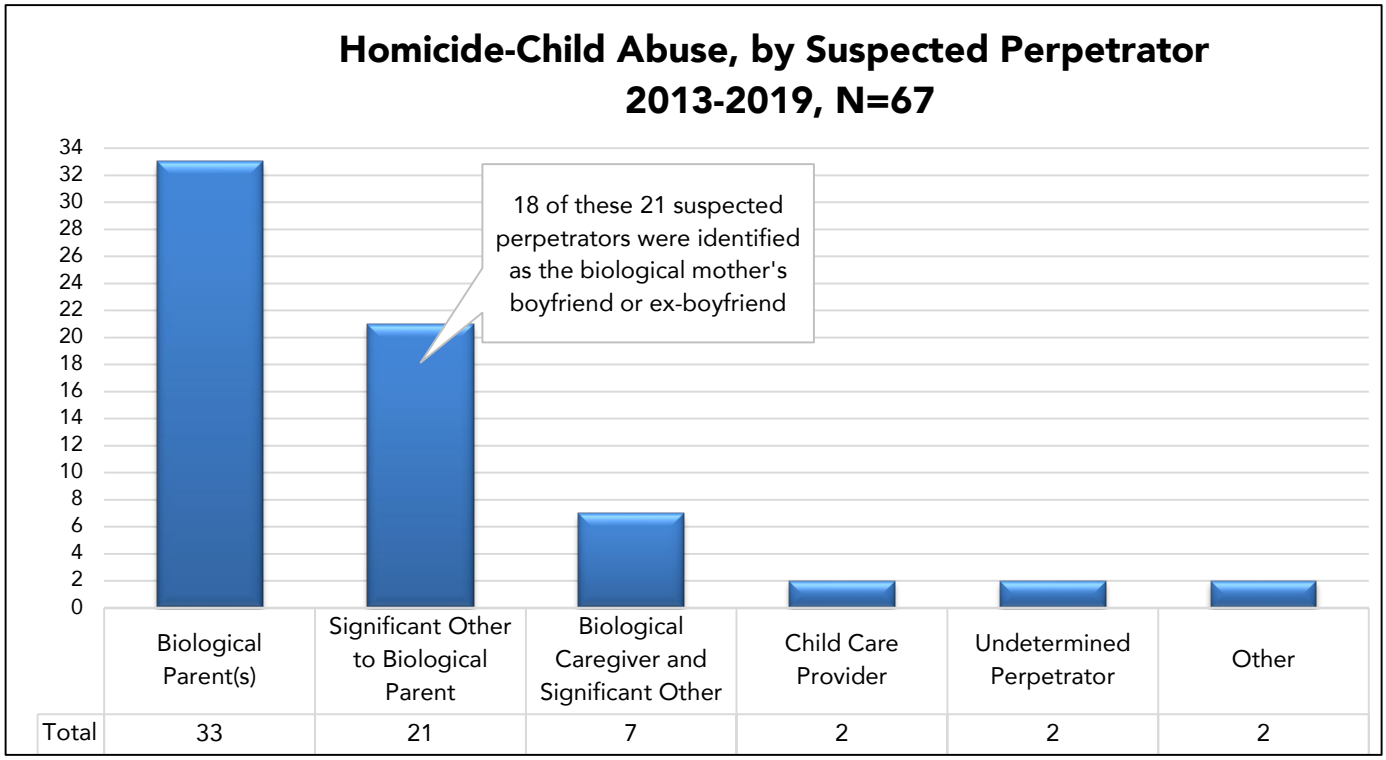
The Board defines Child Abuse Homicide as resulting from abuse (inflicting injury with malicious intent, usually as a form of punishment or out of frustration with a child's crying or perceived misbehavior) or neglect (failing to provide shelter, safety, supervision and nutritional needs) by caretakers. Child abuse is a complex problem that stems from a variety of factors including, but not limited to, financial stressors, domestic violence, substance abuse, mental illness and unreasonable expectations of children's behaviors.

The method of child abuse homicide can vary. In general, most occur as a result of blunt force trauma. The most prevalent form is Abusive Head Trauma (AHT), previously referred to as Shaken Baby or Shaken/Impact Syndrome. AHT occurs when an infant or toddler is severely or violently shaken resulting in serious injury and/or death. When infants are shaken or their heads sustain a severe impact, the brain moves within the skull. The blood vessels and brain tissue cannot tolerate the sheering force caused by the violent shaking. Blood vessels will break causing internal bleeding, and brain cells are damaged. Because of the internal head injuries, the child may encounter trouble breathing or lose consciousness, which can cause additional brain damage due to lack of oxygen. These injuries lead to serious complications such as blindness or eye damage, delay in normal development, seizures, damage to the spinal cord (paralysis), brain damage or death. It is important to note that it is common for children who die from AHT to have autopsy evidence of impact injuries without visible external evidence of trauma.

Caring for children can be overwhelming at times. Often parents and caregivers are facing multiple stressors and may have limited access to support. There are several risk factors associated with child abuse homicide including maternal risk factors (young age, less than 12 years of education, and being a single parent) and household risk factors (non-biological caregiver in the home, prior substantiation of child abuse and neglect, substance abuse, and low socioeconomic status). Many of the child abuse homicides occurred when the primary caregiver was away from the home. Often the child was in the care of the mother's significant other [2] or by a relative who was not the primary caregiver.

Figure 43 categorizes the suspected perpetrators in each of the child abuse homicides over the last seven years. In 49% (33) of these deaths, the suspected perpetrator was a biological parent(s) of the child. Mother's significant other was the suspected perpetrator in 27% (18) of the child abuse homicides. In 10% (7), a biological caregiver and his or her significant other were both responsible for the death. The two child abuse homicides in which the perpetrator was listed as "undetermined" involved cases where the perpetrator could not be determined, usually due to more than one suspect in the case.

Figure 43



SCDRB data reflect characteristics of child abuse homicides from studies in other states. Child abuse homicide is proportionately greater and has findings that are different from those of other child

[2] Significant Other- Used to reference a current or previous non-marriage relationship with no biological relationship to the child.

homicides. Research indicates that the circumstances of infant homicides include a majority of them perpetrated by someone in a caregiving role and who is less than 25 years of age. More than 80% occurred in the child's home and in more than half, there were suspicions of previous abuse of the victim by the perpetrator or another person, or previous abuse of another child by the perpetrator. In sharp contrast to teen homicides where the majority involve guns or knives, the majority of infant and young child homicides are the result of beating, shaking or strangulation by someone entrusted with caring for the child.

Child abuse homicides call for attention aimed at prevention. Effective methods for preventing child abuse involve programs that enhance parenting skills for at-risk parents. Examples include home visits by nurses who provide information on quality childhood programs, coaching in parenting skills which include parent training and education about normal childhood behaviors and age appropriate discipline, and information on how to select appropriate child caregivers. Educational interventions to identify abuse cases before they lead to severe injuries or death, and to teach skills for dealing with angry and impulsive responses to infant crying and frustrating behaviors are needed.

It is crucial that all citizens of Kansas help support families and protect children by reporting any and all suspicion of abuse or neglect. Children rely on those around them to speak up for their well-being when they are unable to do so themselves.

CASE VIGNETTE

CHILD DEATH DUE TO HOMICIDE – CHILD ABUSE

Caregiver Reports Aren't Always Accurate – A young child was reported to have choked while eating dinner. A call to 911 was made and the caregiver started CPR. Medical care was initiated but was unable to save the child's life. At autopsy, the child was found to have a skull fracture, multiple sites of bleeding in the brain and abdominal injuries caused by blunt force trauma. Evidence also showed the child had been exposed to illicit drugs. The history provided by the caregivers did not explain any of the injuries.

DCF assessments regarding the safety and well-being of children are critical – Approximately a month before the death of this child, DCF received a report of alleged physical abuse to the child. The report was still open at the time of death. Ultimately, the case was unsubstantiated by DCF as the caregivers denied abuse and the child did not appear fearful of the caregivers despite the existence of photos of bruising to the child's face. Other concerns were reported to law enforcement by family members but there was no indication that DCF or law enforcement were aware of the reports to the other agency. The child was never evaluated by a child abuse pediatrician.

Board Reflection – All suspicions of child abuse or neglect should be reported to DCF. Every person should help protect children regardless of whether it is mandated by law. The death of this child is one of many the Board has reviewed where reporting could have saved a life. This death is also one of many where the family of the deceased was well known to DCF. It is imperative for the safety of children that law enforcement, education and medical professionals, social services and prosecutors all work together, share information and ensure that thorough investigations into allegations are conducted to protect our most vulnerable children. It is not uncommon for a parent's statement about a previous or current injury to a child to be taken at face value without attempting to corroborate that statement. Statistically, a parent or someone close to the parent is most frequently the perpetrator of the abuse. By failing to interview collateral witnesses, review the family history, consult with others who have contact with the child and obtain medical evaluations, some Kansas children are remaining in dangerous situations that unfortunately have too often caused their death even after concerns about that child or their siblings have been reported to professionals. Some recent cases have been covered extensively in the media; however, it should not be assumed that all such cases receive the same level of media attention. On average, of the child abuse homicides this year, there were nine contacts with DCF prior to the event that caused the child's death. While DCF will not always be able to predict which children will be fatally injured, there are many cases when there was sufficient evidence that the child and/or the siblings were unsafe in the home prior to the death of a child.

HOMICIDE – GANG VIOLENCE

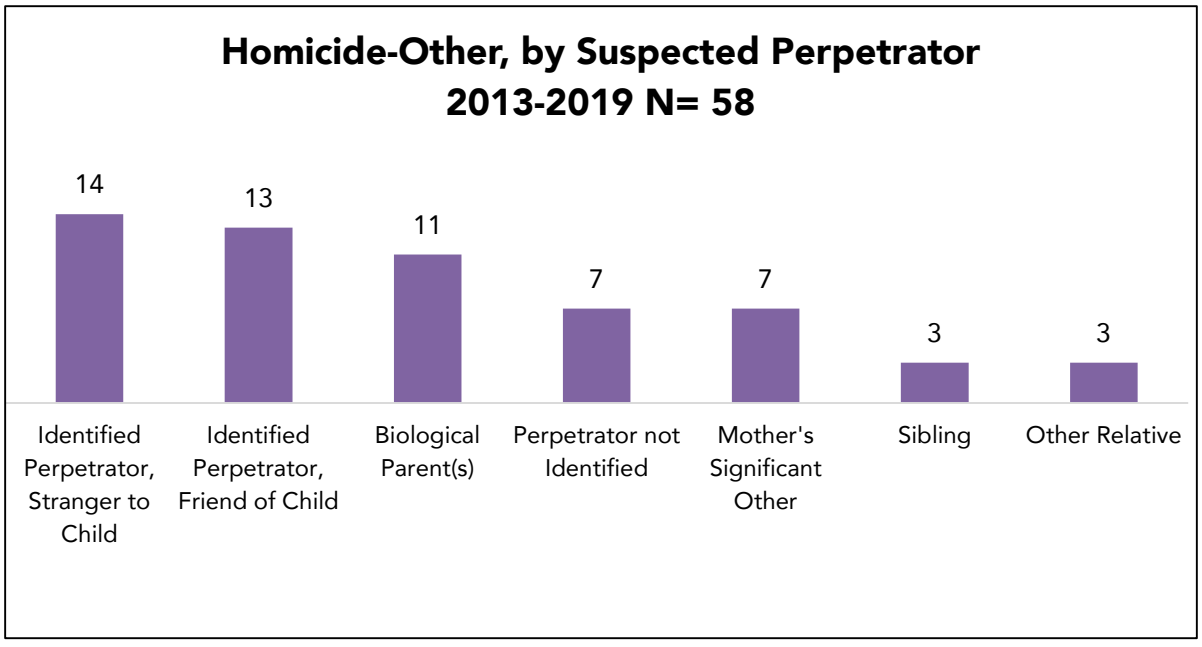
The Board will categorize a homicide as the result of gang violence when there is evidence to support the child died from direct or indirect actions carried out by known or suspected gang members. In many of the cases reviewed, children are at the "wrong place at the wrong time" and unintentionally caught in the gang violence. This can occur while the child is outside playing or even in the safety of his or her own home. A child living in a location with gang activity or in a home that has other household members with gang associations is at significant risk for injury or death. In other circumstances, the children killed are members of a gang and die during disputes related to gang activity.

Between the years of 2013 and 2019 there have been 11 homicides due to gang violence; in seven of the deaths a suspect was identified/charged with the murder. Gun violence was the cause of death in all 11 of these homicides. There were two homicides identified as gang-related in 2019.

HOMICIDE – OTHER

Any death not categorized as Homicide-Child Abuse or Homicide-Gang Violence is categorized as Homicide-Other. In many of these deaths, the act of violence against the child is more random in nature and a clear explanation for why the murder occurred may not be evident. In other situations, there are clear indications why the child was killed, however the circumstances had nothing to do with child abuse or gang-related violence. Figure 44 demonstrates that in 64% of the 58 deaths in this category over the last seven years, the child victim knew the perpetrator. Of the deaths in which the perpetrator was a stranger to the victim or was unidentified, 90% involved gun violence. This is in contrast to only 46% involving gun violence when the child victim knew the perpetrator.

Figure 44



Characteristics of the 23 Child Homicides, 2019

- Eight children died from child abuse, two were under 1 year of age; five were between 1 and 4 years of age; and one was 5-9 years of age at the time of death.
  - 6 of the 8 child abuse homicides had current or past DCF child protective service involvement prior to the fatal incident.
- 16 of the 23 families of homicide victims had current or past DCF child protective service involvement initiated prior to the fatal incident.
- 12 of the 23 incidents occurred at the child's home, including seven of the eight child abuse deaths.
- In 3 of the 23 homicides, the Board found sufficient evidence, after thorough review, to classify the deaths as homicides even though they were not originally classified in that manner. The death certificates in these three cases all noted an undetermined manner of death.

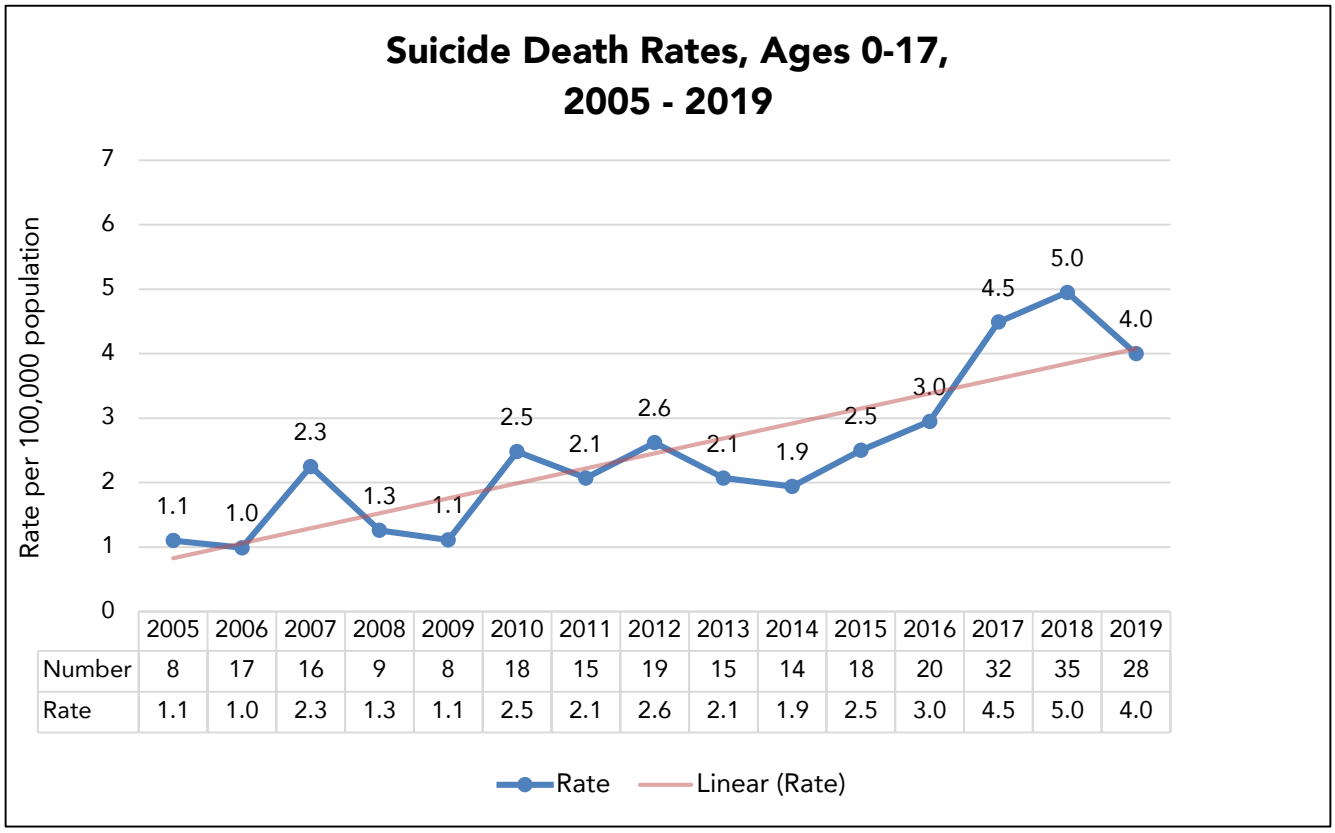
PREVENTION POINTS

- **Family Violence** – The safety of children living in homes where domestic violence occurs needs to be addressed by DCF and law enforcement when visits are made to the home. Children living in such environments are at increased risk of abuse, neglect or death.
- **Drug Environments** – Children living in environments where they are exposed to drugs (including illicit drugs, prescription medication misuse and alcohol abuse) are at increased risk of abuse, neglect or death. If drug use is suspected, the safety of the children should be addressed.
- **Education for Caregivers of Young Children –** The victims of child abuse homicide are most often in the younger age categories. Frustrated caregivers, often without any parenting training, combine unrealistic expectations for children's behavior with a lack of appreciation for their vulnerability. Education should be provided at all points of contact with parents and caregivers, especially addressing positive ways to respond to infant crying and child discipline, supporting parents through stressful periods, and adjusting work policies to give parents quality time with their young children.
- **Education about Signs of Child Abuse –** Most cases of child abuse can be suspected with attention to the characteristics of the injuries. Normal, active children get bruises and bumps from everyday play. These bruises are most often over bony areas such as the knees, elbows, and shins. If a child has injuries on areas such as the cheeks, ears, mouth, stomach, buttocks or thighs, the possibility that the child is being abused must be considered. Bruises in these areas, human bite marks, round burns the size of a cigarette, or larger poorly explained burns seldom come from everyday activities. Young children who are not crawling or walking rarely sustain bruises – "if you don't cruise, you don't bruise." Any bruises noted on a child less than 9 months of age, especially if recurrent, patterned, or in unusual locations on the body should be evaluated for the possibility of abuse.
- **Report any Concerns for Child Abuse and Neglect** – If there is suspicion a child is being abused or neglected, a report should be made to the Kansas Protection Report Center at 1-800-922-5330 (toll-free) or 911 if the child is in imminent danger.

Suicide

In 2019, 28 children in Kansas between the ages of 10-17 died by suicide; 18 were male and 10 were female. According to the Centers for Disease Control and Prevention, in 2019, suicide was the second-leading cause of death among U.S. children 10-14 and young people 15-24 years of age. In Kansas, consistent with national studies, adolescent females are more likely to attempt suicide, but adolescent males are more likely to complete it. Figures 45 and 46 show suicide rates per 100,000 population for children ages 0-17, and by age group for the last 15 years in Kansas. Figure 46 shows that the rate of suicide deaths in the 15-17 age category more than doubled between 2016 and 2017 and remained high in both 2018 and 2019.

Figure 45



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Number	8	17	16	9	8	18	15	19	15	14	18	20	32	35	28
Rate	1.1	1.0	2.3	1.3	1.1	2.5	2.1	2.6	2.1	1.9	2.5	3.0	4.5	5.0	4.0

Figure 46

Suicide Death Rates per 100,000 age-related population, Ages 10-17, by Age Group, 2005-2019		
	Age 10-14	Age 15-17
2005	0.5	5.9
2006	1.6	11.5
2007	2.6	9.1
2008	1.1	5.9
2009	2.7	3.5
2010	1.0	12.5
2011	1.5	10.1
2012	3.0	11.0
2013	2.0	9.3
2014	2.5	7.6
2015	3.0	10.0
2016	3.5	10.8
2017	3.5	21.0
2018	4.5	21.9
2019	3.0	18.5
Average	**2.4**	**11.24**

Various methods are used by children and adolescents who die by suicide. The most common method of suicide for males is the use of a firearm; females more frequently use hanging, suffocation, or drugs. While it is known there is a connection between suicide and vehicular crashes, the number of intentional crashes remains unidentified. Many suicide attempts, as well as suicides reviewed by the Board, occur when the child is in short-term crisis. It is important for parents and caregivers to prevent access to lethal means during periods of increased risk of suicide or self-harm. Figure 47 indicates the methods used by gender of the child over the last 10 years.

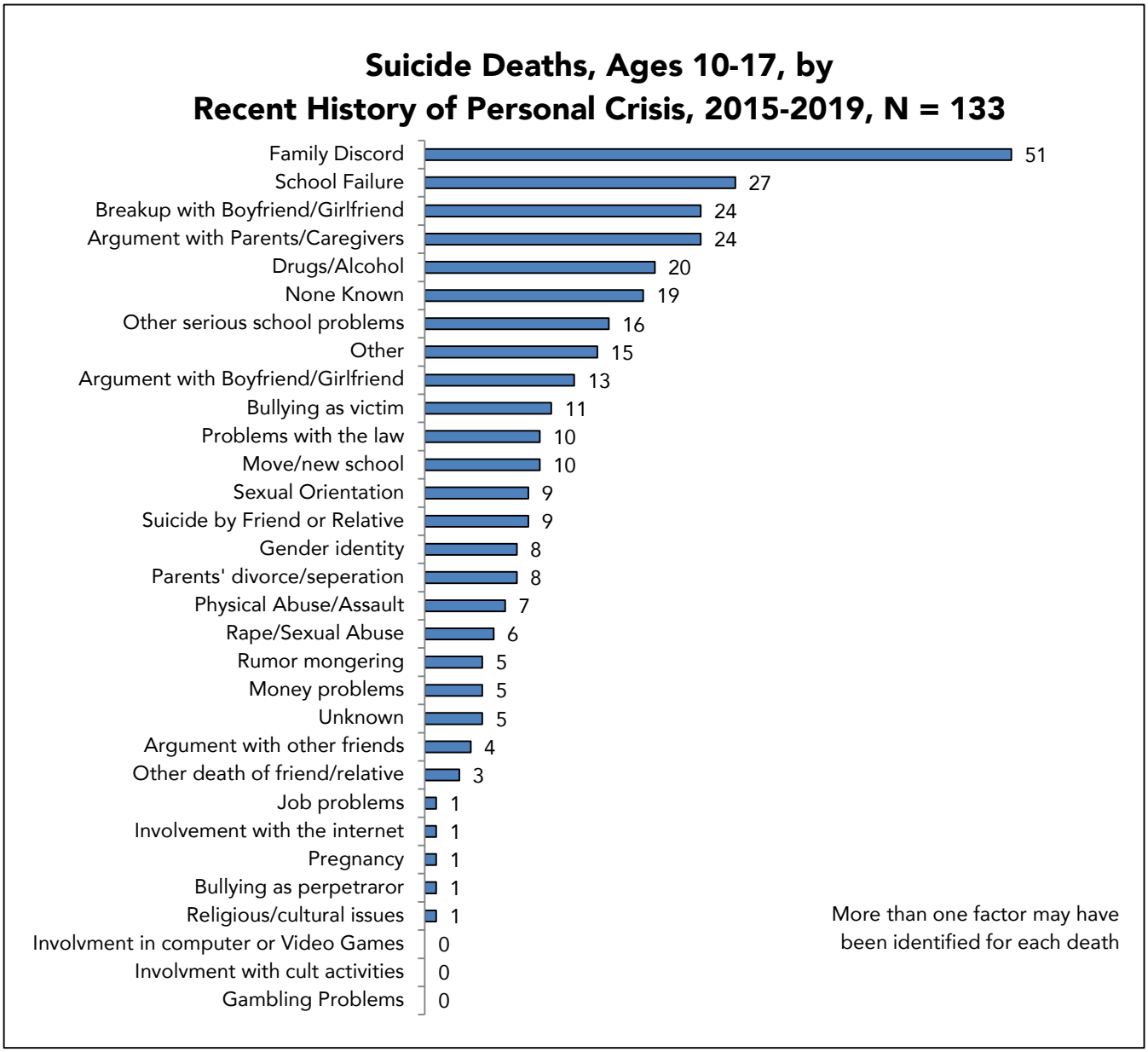
Figure 47

Suicides by Method and Gender, 2010-2019			
Method	**Male**	**Female**	**Total**
Asphyxia	60	39	99
Firearm	81	13	94
Poisoning, Overdose or Acute Intoxication	4	11	15
Other Transport*	1	1	2
Fall or Crush	1	2	3
Undetermined	0	1	1
***Train, Motor Vehicle Crash**			

Risk factors for adolescent suicide are categorized as predisposing and precipitating factors. Predisposing factors include mental health problems and psychiatric disorders, previous suicide attempts, family history of suicide, history of physical or sexual abuse, and exposure to violence. Precipitating factors include access to means, alcohol and drug use, exposure to suicide and suicide attempts, social stress and isolation, and emotional and cognitive factors. Well-identified examples of social stress include parental divorce or separation, gender identity and sexual orientation, or the breakup of a significant relationship. Bullying has been identified as a risk factor, placing both bullies and victims at risk. Additionally, an increased risk for suicide for females has been correlated with a recent family move. An increased risk for males correlates with the loss of a relationship.

Figure 48 lists the recent personal crises associated with the suicides between 2015 and 2019. Of note, in many cases, the family felt the suicide was completely unexpected as the child did not have a history of mental illness, suicidal ideation, or other risk factors associated with suicide. This is important to understand, as suicide is sometimes referred to as a "silent epidemic." Reasons for suicide can be complex and challenging to identify, however some suicides can be prevented. Parents, caregivers, friends, school personnel, and others need an awareness of warning signs to identify those who may be considering harming themselves. There are many protective factors that can buffer individuals from suicidal thoughts and behaviors, including clinical care for mental health and substance abuse, family and community support, and promoting skills in problem solving and conflict resolution.

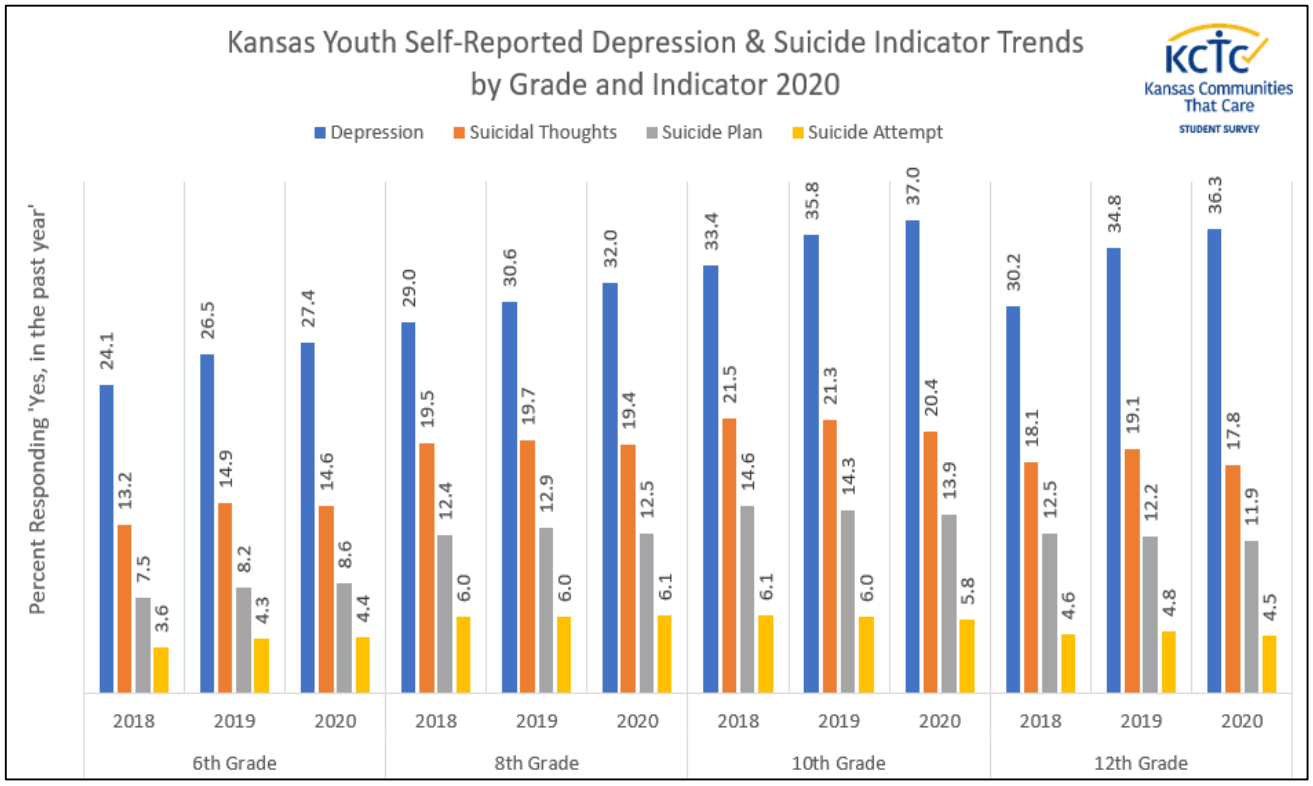
Figure 48



The findings of the Board are consistent with The Kansas Communities That Care (KCTC) Student Survey. The survey is administered annually, free of charge to all public and private schools in Kansas. Figure 49 represents a recent enhancement to the survey which measures youth depression and suicide thoughts, plans and attempts. Youth as young as sixth grade are reporting thoughts, plans and attempts of suicide. Each grade surveyed has shown an increase in self-reported depression between 2018 and 2020.

These self-reported indicators parallel the preliminary data of the Board which show that the rate of Kansas children who died by suicide is not only increasing, but includes children as young as elementary and middle school. Prevention efforts aimed at reducing youth suicide should be offered to children as early as elementary school.

Figure 49



Due to ongoing concern about adolescent suicides, the Kansas Legislature passed SB323 in 2016. This legislation requires suicide prevention training for school district personnel and a building crisis plan be developed for each school that includes steps for recognizing suicide ideation, appropriate methods of intervention, and a crisis recovery plan. This law is modeled after the Jason Flatt Act, making Kansas the 19th state to pass similar legislation since 2007. More information regarding the Jason Flatt Act can be found at http://jasonfoundation.com/.

In further response to the increased rate of youth suicide, Kansas Attorney General Derek Schmidt and the Tower Mental Health Foundation formed the Youth Suicide Prevention Task Force in June 2018, to survey efforts that were currently underway in Kansas to reduce the incidence of youth suicide. In 2019, the Kansas Legislature adopted several of the task force recommendations by passing the conference committee report on HB 2290 that led to the creation of a Youth Suicide Prevention Coordinator position. More information regarding the Youth Suicide Prevention Task Force and their report can be found at http://ag.ks.gov/ysptf.

The Youth Suicide Prevention Coordinator (YSP) has focused on collaboration and coordination with multiple state agencies and community partners to build a sustainable infrastructure to better respond to youth suicide in Kansas. To that end, the YSP coordinator has been an active partner in multiple statewide work groups including: the inter-state agency task group to create a 5-year State Plan to prevent suicide, KDHE's Zero Suicide Initiative, and the advisory group on 988 (national suicide hotline) implementation. Additionally, the Office of the Attorney General (OAG) was able to secure limited funding for the Youth Suicide Prevention mobile app development during the 2021 legislative

session. The YSP Coordinator assisted in drafting a request for proposal for vendors to develop the application. The procurement process has begun to select a vendor with the goal of implementing in SFY 2022. The OAG will be considering ways to increase the capacity of the Youth Suicide Prevention Unit, including increasing the YSP Coordinator to a full-time position, in order to ramp up for these activities.

In addition to continued state policy support regarding youth suicide prevention, the Board notes prevention efforts around the state have been created by families and friends who have experienced a loss to youth suicide. In one particular effort, family and friends were able to raise around $240,000 to start a nonprofit organization called "Keep the Spark Alive," that uses the funds raised to prevent teen suicide by supporting innovative programs and initiatives in Kansas. More information regarding this organization can be found at http://ktsa.org.

It is the Board's hope that there will be continued state, local, and individual responses to the alarming youth suicide epidemic. It is through these actions that we can continue to address, reduce and potentially eliminate youth suicide in Kansas.

Characteristics of the 28 Suicide Deaths, 2019

- 64% had a significant argument or family conflict just prior to the suicide.
- 64% of the suicide deaths were male.
- 61% had recent school problems (academic, behavioral, suspensions, conflicts with peers, truancy, etc.).
- 39% were currently receiving or previously had received mental health services.
- 43% of the decedents had a history of alcohol or substance abuse concerns.
- 25% were known to have attempted suicide previously.
- 25% had a history of being in state custody or had a sibling in state custody prior to suicide.
- 7% were in state custody at the time of their suicide.

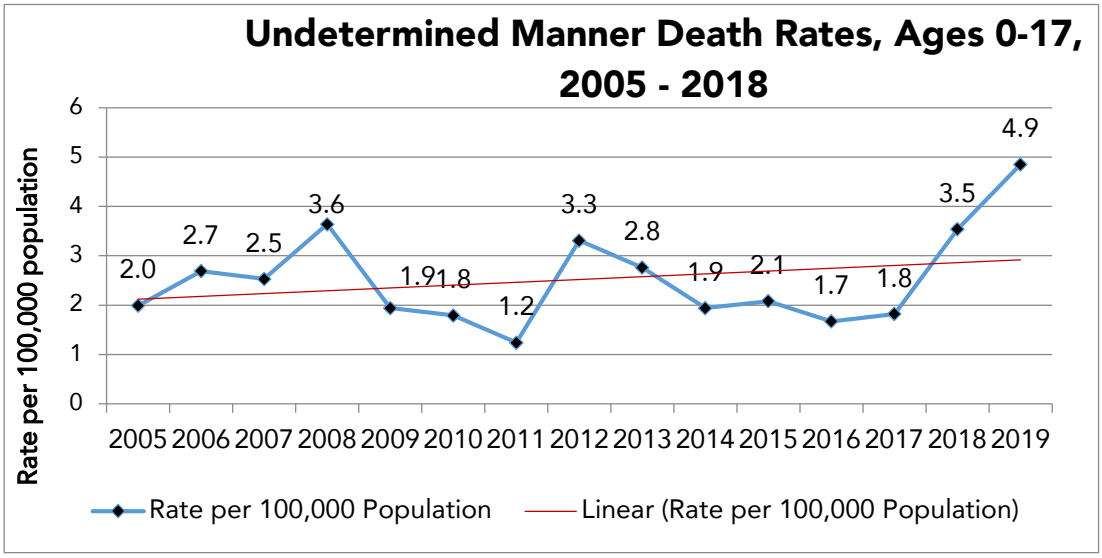
PREVENTION POINTS

- **Early Diagnosis and Treatment of Mental Conditions –** Early involvement of mental health professionals may prevent suicide attempts. Special caution should be taken with children who are taking antidepressant medication as health officials have issued warnings that these medications might increase the risk of hostility, mood swings, aggression and suicide in children and adolescents.
- **Observation of Behaviors –** Changes in a young person's psychological state (increase in rage, anxiety, depression or hopelessness), withdrawal, reckless behavior or substance use indicate a need for intervention.
- **Evaluation of Suicide Threats or Ideation – Do not ignore statements about suicide, even if they seem casual or fake.** The months following a suicide attempt or severe depression are a time of increased risk, no matter how well the child seems to be functioning. This is a critical time for family interaction and securing family support systems.
- **Transition of Treatment** – The transition from inpatient to outpatient behavioral health care is a critical time for patients with a history of suicide risk. Youth discharged from an inpatient care setting are at an increased risk for suicide following hospitalization.
- **Limit Access to Lethal Agents –** Easily obtained or improperly secured firearms and other weapons, and means such as prescription and over the counter medications, are often used in suicides. The more difficult it is for children to put their hands on these items, the more time they have to rethink their intentions, or to allow someone to intervene.
- **Talk About the Issue –** Bringing up suicide does not "give kids the idea" but rather gives them the opportunity to discuss their thoughts and concerns. This communication can be a significant deterrent.
- **Monitor Difficult Situations –** A child's response to parental separation, a relationship breakup, or a peer suicide may include signs or symptoms of depression or hopelessness. Counseling and support to address depression or situational difficulties is imperative.
- **Don't Keep Suicide a Secret –** If a friend or a loved one is considering suicide, promising to keep it a secret delays help and puts a life at risk. Young people should be counseled to tell a friend that help is available. Education about sharing concerns, and how to reach out to a trusted adult, school counselor, or a suicide prevention hotline must be in the hands of all youth.

Undetermined Manner

Unfortunately, the Board encounters cases where questions remain as to the cause or manner of the child's death. When there are multiple circumstances that may have contributed to the child's death or no identifiable cause is established, the Board will classify the death as undetermined. Figure 50 shows Undetermined Manner death rates for the last 15 years of case reviews.

Figure 50



Historically, investigations in the undetermined cases have varied significantly. In some instances, although every effort was made to determine why a death occurred, the cause of death could not be ascertained. Other cases had incomplete investigations or law enforcement agencies were not informed of the death. In some, autopsies were not ordered or were incomplete, or toxicology testing on the victim was not performed even though the circumstances warranted testing.

The sharp increase in cases classified as undetermined in 2019 (Figure 50) is mainly due to reclassifications in sleep-related deaths, which are now being classified Undetermined–SUID instead of Natural-SIDS.

In 2019, there were 34 undetermined deaths. Of those 34 deaths, 28 were Sudden Unexpected Infant Death (SUID), all of which were sleep-related. Of the 28 SUID cases in 2019, eight would have previously been included in the Undetermined Manner category because of concerns that the death may have been the result of neglect, intentional injuries or actions, or had incomplete case information.

In past years, some of the cases were classified as undetermined because of incomplete autopsies. This year all autopsies performed on cases within the undetermined category met basic standards. All non-natural child deaths should be exhaustively investigated. The circumstances and family situation should not affect the detail of the inquiry. Hospitals must have protocols in place to ensure law enforcement is notified when a child dies from other than expected natural causes and when a child is admitted with what appears to be a life-threatening event of unknown etiology that is likely to be fatal.

CASE VIGNETTE

INFANT DEATH DUE TO UNDETERMINED MANNER

Every case needs a thorough and coordinated investigation – An infant was placed to sleep on an unsafe sleep surface. When the caregiver awoke, the infant was found to be unresponsive and later pronounced deceased. The investigation completed by Law Enforcement was minimal and lacked information regarding the circumstances of the death including the sleep position and witness interviews. Due to the lack of information available for the Board to review, this case was finalized as a Sudden Unexplained Infant Death-Incomplete Case information.

Board Reflection – Law Enforcement should utilize the Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) in each investigation of infant deaths. Completion of this form assists the board in determining accurate causes and circumstances around the death and guides investigators through their investigation to ensure that comprehensive and standardized information is collected regarding the incident.

Information regarding the SUIDIRF as well as a link to the fillable form can be found at: https://www.cdc.gov/sids/SUIDRF.htm

Autopsy Examinations – All Manners of Death

In total, for all manners of death, there were nine child deaths in 2019 for which the Kansas coroner or pathologist did not order or complete an autopsy when the Board felt one was warranted by the circumstances, or did not meet the minimum expectations for the autopsy components.

Child Autopsy Guidelines established by the SCDRB indicate that in addition to a thorough investigation, the standards for an autopsy as it relates to an unexplained child death should include at a minimum, the following as appropriate for the age and circumstances of the child at death:

- Photographs of the child and of all external and pertinent internal injuries or findings.
- Examination of all clothing and items accompanying the body, preserving all materials for later examination by a crime lab.
- Documentation of evidence of therapy and resuscitation.
- Radiographs for a complete survey of the skeletal structures, especially in children less than 2 years of age; films should be reviewed by a radiologist or physician experienced in child trauma whenever possible.
- Blood, urine and vitreous should be collected for use as an adjunct to toxicology or if metabolic or hydration status could be a concern.
- Toxicological studies should include ethanol and common drugs of abuse, including cold medications, if being used; prescription drugs should be tested for based on history and scene investigation.
- The external examination should give consideration to and document the general appearance, cleanliness, nutrition (heights and weights compared to standard growth charts), dehydration, failure to thrive, congenital anomalies, evidence of abuse or neglect, evidence of sexual abuse; if not found, these should be recorded as essential negative findings.
- An autopsy should be performed on an unembalmed body and include in-situ examination of the brain, neck structures, thoraco-abdominal and pelvic organs with removal and dissection. Weights of organs should be documented. In suspected injury cases, lengthwise incisions through skin and subcutaneous tissues should document the depth of the hemorrhage. If there is no gross cause of death, or if otherwise indicated by gross findings, microscopic examination should be conducted on the brain, heart, lungs, liver, kidneys and other organs as indicated. Stock tissue and paraffin blocks should be retained.
- DNA should be archived for genetic testing, if indicated.
- Metabolic screening results should be determined from the medical birth record. In cases where a metabolic condition is considered (e.g. preceding viral illness, period of starvation, nocturnal death, positive findings such as fatty liver), particularly in children under 2 years of age, further tissues should be preserved. A blood spot card should be prepared and retained in case autopsy findings suggest a metabolic disorder.

Child Autopsy Guidelines created by the Board can be found at:
https://ag.ks.gov/about-the-office/affiliated-orgs/scdrb.

Combined with thorough law enforcement investigations, complete autopsies often provide a better understanding of child deaths. However, there are situations in which an autopsy should have been performed and was not, or the autopsy did not include all aspects of a standard forensic investigation such as full-body x-rays, cultures, metabolic and toxicological studies. Kansas is in need of improvements in the coroner system to include standards for medicolegal death investigation, procedures, and appropriate filing of causes of deaths. Reimbursement opportunities are available for child autopsies through the District Coroner's fund managed by KDHE. More information is available at the SCDRB's website: http://ag.ks.gov/scdrb.

There were nine Kansas cases in 2019 where the Board determined that an autopsy either should have been conducted, or was not properly conducted; those nine cases are noted by the judicial district that held jurisdiction of the death in Figure 51. As noted above, the Board has established protocols and guidelines for child autopsies.

Kansas Counties by Judicial District

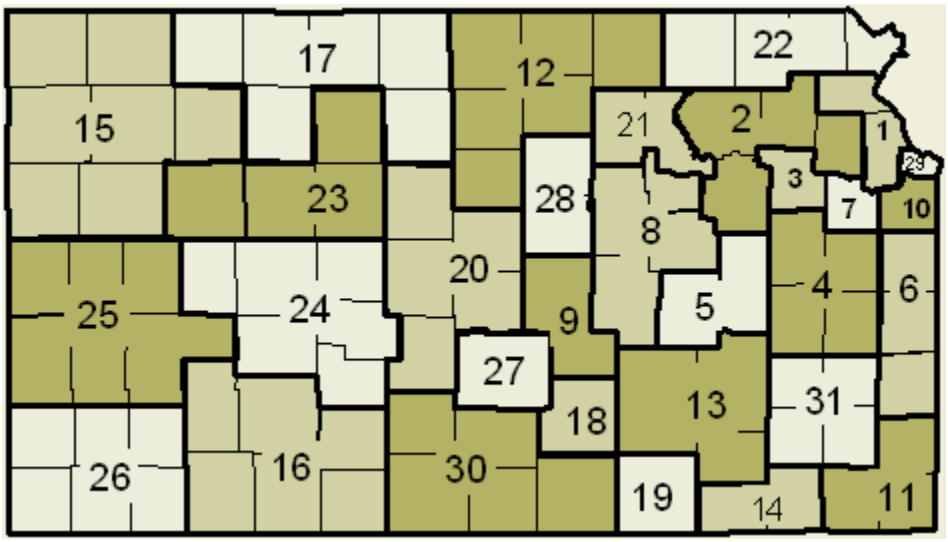


Figure 51

District	Counties in District	# of child deaths not autopsied, despite guidelines		# of child deaths incompletely autopsied, despite guidelines	
		2015-2018	2019	2015-2018	2019
District 1	Atchison, Leavenworth	1	0	0	0
District 10	Johnson	1	0	2	0
District 12	Cloud, Jewell, Lincoln, Mitchell, Republic, Washington	2	4	0	0
District 13	Butler, Elk, Greenwood	1	0	0	0
District 15	Cheyenne, Logan, Rawlins, Sheridan, Sherman, Thomas, Wallace	2	0	3	1
District 16	Clark, Comanche, Ford, Gray, Kiowa, Meade	7	0	1	0
District 17	Decatur, Graham, Norton, Osborne, Phillips, Smith	0	0	1	0
District 18	Sedgwick	0	0	1	1
District 19	Cowley	0	1	0	0
District 20	Barton, Ellsworth, Rice, Russell, Stafford	2	0	5	0
District 23	Ellis, Gove, Rooks, Trego	3	0	4	0
District 24	Edwards, Hodgeman, Lane, Ness, Pawnee, Rush	0	0	1	0
District 25	Finney, Greeley, Hamilton, Kearny, Scott, Wichita	1	1	0	0
District 27	Reno	1	0	0	0
District 28	Ottawa, Salina	0	0	1	0
District 29	Wyandotte	1	0	0	1
District 30	Barber, Harper, Kingman, Pratt, Sumner	2	0	0	0

SCDRB Public Policy Recommendations

The Board strongly encourages consideration of each of the following policy recommendations:

Recommendations to Prevent Child Abuse and Neglect Deaths

Increase Access to Affordable, High-Quality Child Care

Homicides, particularly of children under the age of 3, continue to occur when children are left in the care of persons who are unprepared or unable to care for them.

KDHE and DCF should continue working towards ensuring families have access to high quality and affordable child care. Children, and particularly young children, should be cared for by persons who are experienced and have reasonable expectations for children and their behaviors. Having access to affordable, high-quality childcare would help decrease future child deaths.

Policies that expand access to community-based home nurse visitation programs for all families with new infants and ensure paid parental leave for families should receive state support.

Enhance Training and Access to Appropriate Information for Child Welfare Professionals

Kansas DCF should continue to develop and provide enhanced training for both their employees as well as employees of all contracted agencies. It is imperative that every employee of each agency charged with the investigation of abuse and neglect or assessing the continued risk of children under their supervision or custody have current, high quality training regarding child abuse and neglect as well as other topics related to safety assessment.

Through privatization of many parts of the state child welfare system, additional issues have developed regarding the flow of information to all necessary persons. In reviewing DCF files in situations where children and their families were receiving services, it is apparent that workers who had frequent interaction with the families were unaware of information DCF had regarding a particular family. Each report should not be looked at as an individual incident, but all available information should be reviewed in its entirety to look for repeated reports of similar behavior prior to developing case plans or making recommendations regarding a child.

Kansas DCF cannot address allegations and concerns of abuse or neglect without thorough historical and investigative information in a form that is comprehensive and easily accessible. Medical histories and law enforcement investigative information about the child is critical for DCF assessments regarding the safety and well-being of a child. Medical providers who report suspicions of abuse or neglect must provide medical information and records appropriate to the case investigation.

Improve Reporting of Child Abuse and Neglect

In Kansas, mandated reporters are required to report child abuse or neglect as directed by Kansas law (K.S.A. 38-2223). Concerned citizens who suspect child abuse or neglect are also encouraged to report concerns to DCF.

Public policy campaigns should be launched to educate all Kansans on when, how, and why they should report concerns of child abuse or neglect. Additionally, mandated reporters need continued trainings regarding reporting laws and the process to report concerns accurately and appropriately. As described in the vignette on page 48 and in other locations throughout this Board report, there are several instances each year where mandated reporters and concerned citizens had information that could have saved the life of a child had the information been reported prior to the death.

Recommendations to Prevent Youth Suicides

Increase Accessibility to Crisis Services and Mental Health Services for Youth within Kansas Communities

Community Mental Health Centers should continue to increase outreach to raise awareness of available mental health services for children and youth, and to ensure parents, caregivers, educators, and other community members are aware of the resources in their community and the state.

The Board is pleased to recognize some steps taken to address the accessibility of crisis and mental health services for all Kansans. This past year State agencies and mental health providers worked to increase the availability of community crisis response for those in mental health distress. Additionally, the Legislature held hearings on the topic of mental health modernization and passed a bill that established certified community behavioral health clinics (CCBHC) as the model for providing behavioral health services in Kansas (HB 2208). CCBHCs are specifically designed to address the suicide crisis, overdose deaths, barriers to timely access to addiction and mental health treatment, delayed care, inadequate care for veterans, and overburdened jail and emergency departments; all of which affect the Kansas mental health system. At the time of this report, six Kansas community mental health centers (CMHC) are in the process of implementing the CCBHC model, and it is anticipated that all 26 licensed CMHCs will transition to CCBHCs over the next three years (Source: KDADS press release, April 27, 2021).

While these improvements are encouraging, the Board encourages community mental health centers, psychiatric treatment facilities, and other agencies providing mental health services to prepare for an increase in demand of their services following the youth application implementation. Additionally, the Board would recommend that five-year State plan which focuses on youth suicide as an expansion of the work of the multi-state agency workgroup.

Increase the Depth of Suicide Investigations

Law enforcement should increase the depth of suicide investigations to include social, mental health and medical histories of the child. Information regarding family stressors, past history of attempts,

involvement in mental health services, and relevant social media information should be included. The Board recommends initiating a policy of standard training and the use of a protocol for suicide investigations, including the use of a suicide death scene investigation form to assist in collecting all pertinent information. By better understanding the contributing factors and precipitating events leading to youth suicide, Kansas will be better equipped to understand these deaths and how to prevent them.

Ensure Training of Education Professionals Regarding the Prevention, Assessment, and Intervention of Suicide

All public school personnel must comply with required annual training that provides practical guidance and best practices on the proactive development and implementation of programs to assess risk of suicide and intervene effectively. Educators and school personnel are in a position to best identify at-risk children as well as support other children if a peer has committed suicide. This is particularly crucial as deaths due to suicide are increasing and include more children of younger ages.

Recommendations to Prevent Motor Vehicle Deaths of Children and Youth

Strengthen All-Terrain Vehicle (ATV) Usage Laws

Citizens and lawmakers should support efforts to impose minimum age requirements of 16 years of age to operate ATVs. Furthermore, requirements that both operators and passengers wear a helmet and be properly restrained should be explored.

ATV use in Kansas continues to increase, as does the risk for serious injury and death when operated by young children. According to the 2020 Annual Report of ATV-Related Deaths and Injuries published by the U.S. Consumer Product Safety Commission, there have been 353 ATV-related fatalities of children under the age of 16, between January 1, 2015, and December 31, 2017. Almost half (48%) of all under-age-16 child fatalities occurred to children 12 and under. Kansas experienced one ATV-related child deaths in 2019.

Strengthen Seat Belt Usage

Citizens and lawmakers should support efforts in Kansas that aim to increase the use of seatbelts and proper restraints by drivers and child passengers. Two considerations being requested are:

- Children from birth to 2 years old must be secured in a rear-facing child passenger restraint system which meets federal standards in the rear vehicle seat until the child exceeds the height or weight limit allowed by the manufacturer of the child restraint being used.
- Children who are younger than 13 must be transported in the rear seat of the vehicle, when available.

Between 2015 and 2019, 52% of the children who died due to motor vehicle crashes were unrestrained or improperly restrained. In another 10% the restraint use of the victim was unknown. According to the State of Kansas Highway Safety Plan Federal Fiscal Year (FFY) 2021, “Children are much more likely to be buckled up if the driver is also belted. If the driver is belted, about 97% of the children are also

belted. If the driver is not belted, only about 30% of the observed children were also belted." Efforts to increase the number of drivers who are properly restrained will also increase the likelihood that our children will be properly restrained. In 2017, legislation passed in Kansas increased the fine for those who are unrestrained. The Board is hopeful that improved legislation will help decrease the number of Kansas children who are unrestrained.

Decrease Distracted Driving in Kansas

Citizens and lawmakers should support efforts in Kansas to promote and encourage individuals to reduce the use of hand-held devices while operating a motor vehicle. According to the State of Kansas Highway Safety Plan Federal Fiscal Year (FFY) 2021, "Distracted driving is listed as a contributing circumstance for about 25% of all reported crashes in the state." Ordinances, promotional materials, advertising and enforcement of current laws can all be effective ways to encourage Kansas drivers to avoid distractions while driving.

Improve Investigations and Strengthen Penalties for Providing Alcohol to Minors

Six decedents were teen drivers under the influence of drugs and/or alcohol at the time of their crash (2018-2019). Thorough investigations of social hosting as well as increased penalties for providing alcohol to children and teens will help deter adults from providing alcohol to children and decrease alcohol related motor vehicle crashes and deaths. The public should be aware of the dangers of teen drinking.

Increase Public Awareness Regarding Pedestrian Deaths in Kansas

In 2019, Kansas experienced six pedestrian deaths of children, three of which took place in the driveway or parking area. According to KidsAndCars.org, at least 50 children are backed over every week in the United States because a driver did not see the child. Public campaigns to encourage drivers to "look before you leave" should be promoted and drivers should be encouraged to walk completely around their vehicle and ensure children are secured prior to backing up their vehicle.

Other efforts that could reduce the number of pedestrian deaths in Kansas would be to educate children of all ages about the dangers of walking while distracted. According to the Safe Kids Worldwide publication, *Alarming Dangers in School Zones,* published in October 2016, there are five teen pedestrian deaths every week in the United States. Walking while distracted by technology, such as cell phones, earbuds and headphones, increases the risk of pedestrian injury and should be avoided. Furthermore, reminders to children and youth to look both ways before crossing a road, and to avoid foot or bike travel at night are helpful reminders that could aid in preventing pedestrian deaths.

Recommendations to Prevent Sleep-Related Deaths

Increase Education on Safe Sleep for Parents and Caregivers

Hospitals with obstetrical services in Kansas have adopted policies regarding safe sleep of infants while hospitalized, and regarding education of all parents prior to discharge from the hospital. The

board supports these policies and practices, and encourages hospitals to include statistics on sleep-related deaths, and to assure regular monitoring of practices and messaging in the hospitals to assure accuracy and consistency in supporting the ABCs of safe sleep: **A**lone on their **B**acks in a **C**rib.

Professionals should use sleep-related suffocation language to clarify for parents that in many cases of sleep-related deaths, children do not die from unexplained reasons but due to overlay, positional asphyxia and other forms of suffocation/strangulation. Parents and caregivers should always comply with the ABCs of safe sleep. Enhanced education and provision of consistent messages about safe sleep is critical for primary care physicians, child care providers and at-risk populations in the state, including low-income and adolescent parents. Required training for DCF investigators and support workers regarding safe sleep should be considered since home visits are an additional educational opportunity for at risk parents.

Recommendations to Prevent Unintentional Injury Deaths

Strengthen Requirements for Personal Floatation Device use in Public Waters

Citizens and lawmakers should support efforts to establish a minimum requirement that any person age 12 or under who is on board any watercraft in the waters of Kansas or who is wading or swimming in navigable public waters shall wear a personal floatation device which is approved by the United States Coast Guard. Between the years of 2010 and 2019, 39% of the drowning deaths of children in Kansas occurred in open water where personal floatation devices were not used. Ensuring that Kansas children are able to swim and properly outfitted with personal floatation devices will save lives.

Recommendations to Improve the Quality of Investigations and Prosecution of Child Deaths and Near Fatalities

Adopt and Consistently Follow a Best-Practices Approach in the Investigation of All Allegations of Abuse and Neglect

The Board was encouraged by House Sub. For SB 126 (2017) which directed the Secretary for Children and Families to establish a Child Welfare System Task Force to study the child welfare system in Kansas. The Child Welfare System Task Force proposed several recommendations in their report to the 2019 Kansas Legislature, which align with recommendations proposed by the SCDRB over the last several reporting years. Information regarding The Child Welfare System Task Force and their report can be found at: http://www.dcf.ks.gov/Agency/CWSTF/Pages/default.aspx

While the Board acknowledges the financial limitations faced by all agencies and branches of government, until appropriate resources are available to provide a thorough, consistent and adequate investigation of all allegations of abuse and neglect, Kansas children will continue to be at risk. The deaths of several children in recent years have been widely reported in the media due to concerns about DCF actions or inactions; those deaths are not isolated examples. It is a continuing concern of the Board that all investigations of abuse and neglect be thorough and fact based, and that any

confidentiality restrictions placed on DCF that prevent them from investigating collateral sources be removed. Additionally, K.S.A. 38-2226 requires a joint investigation between law enforcement and DCF in cases of serious physical harm to or sexual abuse of a child. It is important that both the law enforcement and social work perspective are present in all such investigations.

DCF and law enforcement should review and adopt a best practice approach for the investigation of all allegations of abuse and neglect. Once adopted, training should be conducted with all employees to ensure they understand the scope and extent of investigation necessary in all allegations of abuse and neglect. Those standards for investigation should be carried out consistently among workers, law enforcement officers and among regions of the state. Caseloads should be limited to ensure investigators have adequate time to investigate and follow up on allegations of abuse and neglect. Additionally, funding should be adequate to allow for the hiring of qualified, experienced investigators to perform those investigations and supervise contractors appropriately.

All investigative information obtained should be evaluated in an objective manner. An uncorroborated denial by a parent, in and of itself, should never be grounds for unsubstantiating a claim of abuse or neglect when there is other credible evidence to support such a finding. DCF should also consider any other information collected through law enforcement investigations and any prior or related judicial proceedings in evaluating whether an adult should be substantiated for purposes of the child abuse registry. Workers who consistently fail to conduct adequate investigations should receive additional training to correct those deficiencies or have disciplinary action taken if necessary.

Prior history and investigations should be reviewed before placement of any children. DCF and contracted providers should also develop a reliable system to ensure they have all relevant and necessary information for children in their custody in order that the child's health and well-being does not rely on the child or a relative to provide necessary information to the contractor or DCF. A child's safety should not be compromised because the case decision-maker did not have access to relevant information when making placement decisions.

A primary goal for Kansas is to reduce the need for foster care and the number of children in out of home placements by expanding prevention services to allow more children to remain in their homes if it is safe for them to do so. Increased access to trauma-informed, evidence-based prevention services is crucial to address the most common risk factors for abuse and neglect and to support families. The Board is encouraged by the implementation of Family First Prevention Services through DCF. With additional prevention services, it is anticipated the number of children able to remain safely in their homes will increase. Family First Prevention Services adds new programs, delivered by qualified clinicians, in the areas of mental health, substance use disorder and treatment services, as well as a kinship navigator and parent skill-based program. Family First Prevention Services may be provided to families when at least one child in the home is at imminent risk for out-of- home placement. The Board recommends that similar services continue to be expanded so they are easily accessible to all at risk families throughout the state regardless of geographic location.

Improve the Quality of Law Enforcement Investigations for Infant Deaths

Referrals made to law enforcement regarding child abuse and neglect should be investigated by a trained and experienced investigator. Law enforcement agencies should expand knowledge of child fatality investigation through high quality training including the adoption of the Center for Disease Control's Sudden Unexpected Infant Death Investigation (SUIDI) protocols, and the use of scene recreation and photography. Each year the Board reviews deaths of infants in which law enforcement did not collect adequate information in the investigation for the Board to determine a cause of death.

The Board recommends that Kansas law enforcement adopt procedures based upon best practices regarding the investigation of child abuse or neglect and child death investigations and that a portion of each law enforcement officers annual training include training on child physical abuse and neglect and sexual abuse. Once adopted, training should be conducted with all law enforcement officers to ensure they understand the scope and extent of the investigation necessary in all infant deaths. Those standards for investigation should be carried out consistently among officers in all jurisdictions.

Improve the Quality of Prosecutorial Decision-Making Regarding Infant Deaths

All prosecutors tasked with reviewing infant death cases should have specialized knowledge or should consult with other prosecutors with such specialized knowledge to assist in reviewing evidence in cases where criminal conduct is suspected. Particularly, child abuse homicide cases require a heightened level of knowledge and experience in order to reach informed, well-reasoned decisions that are consistent throughout the state.

Prosecutors should also work with local law enforcement agencies and DCF to assure a coordinated effort toward using a best practices approach to the investigation of all allegations of abuse and neglect.

Improve Coordination and Communication Between DCF and Law Enforcement

Kansas DCF should immediately notify law enforcement in instances where the reported abuse may be criminal in nature for law enforcement investigation. K.S.A. 38-2226 requires a joint investigation if there is a report of child abuse or neglect that indicates serious physical harm or sexual abuse and that action may be required to protect the child. Law Enforcement receiving a report of abuse or neglect should assure that a DCF intake is made.

DCF and health care providers, including hospitals, should report any unwitnessed, unexplained or suspicious death or near death of a child to law enforcement for investigation. The Board has reviewed many cases in which law enforcement was either not contacted, or not notified in a timely manner, thus impeding the ability of law enforcement to conduct a thorough investigation. The investigations should be a coordinated effort by DCF and law enforcement to ensure thorough investigations and the safety of surviving children.

Improve the Quality of Forensic Investigations and Autopsies of Child Deaths

Forensic investigation currently occurs at the county level, which often leads to inconsistency in the way cases are investigated and autopsied. Kansas should consider coordinated oversight of forensic investigations at a state level. Until that capacity is established, the State Child Death Review Board recommends new and existing coroners be required to receive adequate and continuing education regarding the capacity of their duties and to ensure consistency in investigations and declarations of child death determinations.

Forensic pathologists who perform autopsies of children should continue to use the most up-to-date best practices as established by accreditation agencies, such as those standards published by the National Association of Medical Examiners.

Thorough and complete investigations and autopsies are essential for proper death certification and eventual review and analysis of the circumstances of infant, child and adolescent deaths. Coroners and/or medicolegal death investigators should respond to all unexpected child death scenes and coordinate their investigation with law enforcement. A doll re-enactment should be completed for any sleep-related death of an infant with appropriate photo documentation.

The Coroner/Medical Examiner should investigate all:

- Known or suspected non-natural deaths, including those due to violence, trauma, drugs or associated with police action;
- Unexpected or unexplained deaths of infants and children, including those with underlying or chronic illness;
- Deaths occurring under unusual or suspicious circumstances;
- Deaths of children or youth in custody;
- Deaths known or suspected to involve diseases constituting a threat to public health; or
- Deaths of persons not under the care of a physician.

A forensic pathologist should perform the autopsy when the:

- Death is known or suspected to have been caused by violence, trauma, drugs or associated with police action;
- Death occurs in custody of a local, state, or federal institution;
- Death is unexpected and unexplained in an infant or child;
- Death is due to acute workplace injury;
- Death is the result of a motor vehicle crash. Clinical judgment is recommended in the case of delayed deaths;
- Death is caused by or involves apparent injury, including but not limited to electrocution, fire, chemical exposure, intoxication by alcohol, drugs, or poison, unwitnessed or suspected drowning or fall;
- Body is unidentified and the autopsy may aid in identification; or
- Death is unexpected, including those that are sports related, suicides, possible cardiac related and motor vehicle crashes.

Coroners and/or medicolegal death investigators should respond to all unexpected child death scenes and coordinate their investigation with law enforcement. A doll re-enactment should be completed for any sleep-related death of an infant with appropriate photo documentation.

Appendix A: Deaths by County of Residence, 2015-2019

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
Allen	14,193	13	91.59	7	0	1	1	0	1	3
Anderson	9,831	7	71.2	4	1	1	0	0	1	0
Atchison	18,897	10	52.92	7	0	0	0	0	2	1
Barber	5,252	4	76.16	3	0	0	0	0	1	0
Barton	31,688	12	37.87	7	0	1	0	2	0	2
Bourbon	18,731	11	58.73	7	0	3	0	1	0	0
Brown	12,167	7	57.53	6	1	0	0	0	0	0
Butler	85,670	32	37.35	20	1	1	3	1	2	4
Chase	2,736	0	0	0	0	0	0	0	0	0
Chautauqua	3,398	1	29.43	1	0	0	0	0	0	0
Cherokee	23,522	9	38.26	4	2	2	0	0	1	0
Cheyenne	2,822	0	0	0	0	0	0	0	0	0
Clark	2,492	1	40.13	0	0	1	0	0	0	0
Clay	9,491	6	63.22	4	0	0	1	0	1	0
Cloud	10,143	9	88.73	4	1	2	1	0	0	1
Coffey	9,107	5	54.9	1	1	3	0	0	0	0
Comanche	2,176	3	137.87	2	0	0	0	0	0	1
Cowley	42,040	23	54.71	12	0	3	1	4	2	1
Crawford	42,632	17	39.88	13	1	2	0	0	0	1

*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

Appendix A: Deaths by County of Residence, 2015-2019, continued

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
Decatur	2,849	3	105.3	0	2	0	0	0	1	0
Dickinson	22,526	18	79.91	8	2	3	0	1	3	1
Doniphan	8,125	6	73.85	5	1	0	0	0	0	0
Douglas	111,527	46	41.25	26	2	7	4	1	1	5
Edwards	3,372	2	59.31	1	0	0	0	0	1	0
Elk	2,683	7	260.9	1	4	0	2	0	0	0
Ellis	31,018	17	54.81	10	1	1	0	1	1	3
Ellsworth	5,698	2	35.1	1	0	1	0	0	0	0
Finney	56,271	31	55.09	20	1	3	1	2	1	3
Ford	51,396	37	71.99	20	6	3	1	0	6	1
Franklin	31,052	17	54.75	10	3	3	0	0	1	0
Geary	52,376	40	76.37	27	4	2	2	1	3	1
Gove	3,159	2	63.31	1	1	0	0	0	0	0
Graham	2,568	1	38.94	0	0	0	0	0	0	0
Grant	11,631	7	60.18	2	1	0	0	3	0	1
Gray	8,774	3	34.19	2	0	1	0	0	0	0
Greeley	1,640	0	0	0	0	0	0	0	0	0
Greenwood	6,501	8	123.06	4	2	0	1	1	0	0
Hamilton	3,750	3	80	2	0	0	0	0	1	0
Harper	6,938	3	43.24	1	1	0	0	0	0	1
Harvey	42,450	22	51.83	15	0	0	2	2	1	2
Haskell	5,729	4	69.82	3	1	0	0	0	0	0
Hodgeman	2,075	2	96.39	1	0	0	0	1	0	0
Jackson	16,649	11	66.07	5	1	2	2	0	0	1
Jefferson	21,815	9	41.26	5	1	2	0	0	1	0

*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
Jewell	2,767	2	72.28	1	1	0	0	0	0	0
Johnson	727,134	252	34.66	155	18	18	10	9	33	9
Kearny	5,691	6	105.43	4	1	0	0	0	1	0
Kingman	8,171	3	36.72	0	2	0	1	0	0	0
Kiowa	2,823	2	70.85	1	1	0	0	0	0	0
Labette	23,861	14	58.67	8	1	2	1	1	1	0
Lane	1,759	0	0	0	0	0	0	0	0	0
Leavenworth	95,931	48	50.04	31	3	6	3	3	0	2
Lincoln	3,466	1	28.85	1	0	0	0	0	0	0
Linn	10,990	8	72.79	4	2	1	0	0	1	0
Logan	3,324	1	30.08	0	1	0	0	0	0	0
Lyon	37,157	22	59.21	15	2	3	1	0	0	1
Marion	12,747	8	62.76	4	0	1	2	0	0	1
Marshall	11,594	4	34.5	2	0	2	0	0	0	0
McPherson	32,953	12	36.42	8	3	0	0	0	1	0
Meade	5,473	4	73.09	2	1	0	0	1	0	0
Miami	41,441	18	43.44	5	7	4	0	0	2	0
Mitchell	6,994	3	42.89	2	1	0	0	0	0	0
Montgomery	38,543	24	62.27	12	4	4	1	0	1	2
Morris	5,685	3	52.77	3	0	0	0	0	0	0
Morton	3,425	3	87.59	3	0	0	0	0	0	0
Nemaha	13,419	7	52.16	3	3	1	0	0	0	0
Neosho	19,808	14	70.68	5	5	1	0	0	0	2
Ness	3,117	3	96.25	2	0	0	0	0	1	0
Norton	5,176	3	57.96	2	0	1	0	0	0	0

*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

Appendix A: Deaths by County of Residence, 2015-2019, continued

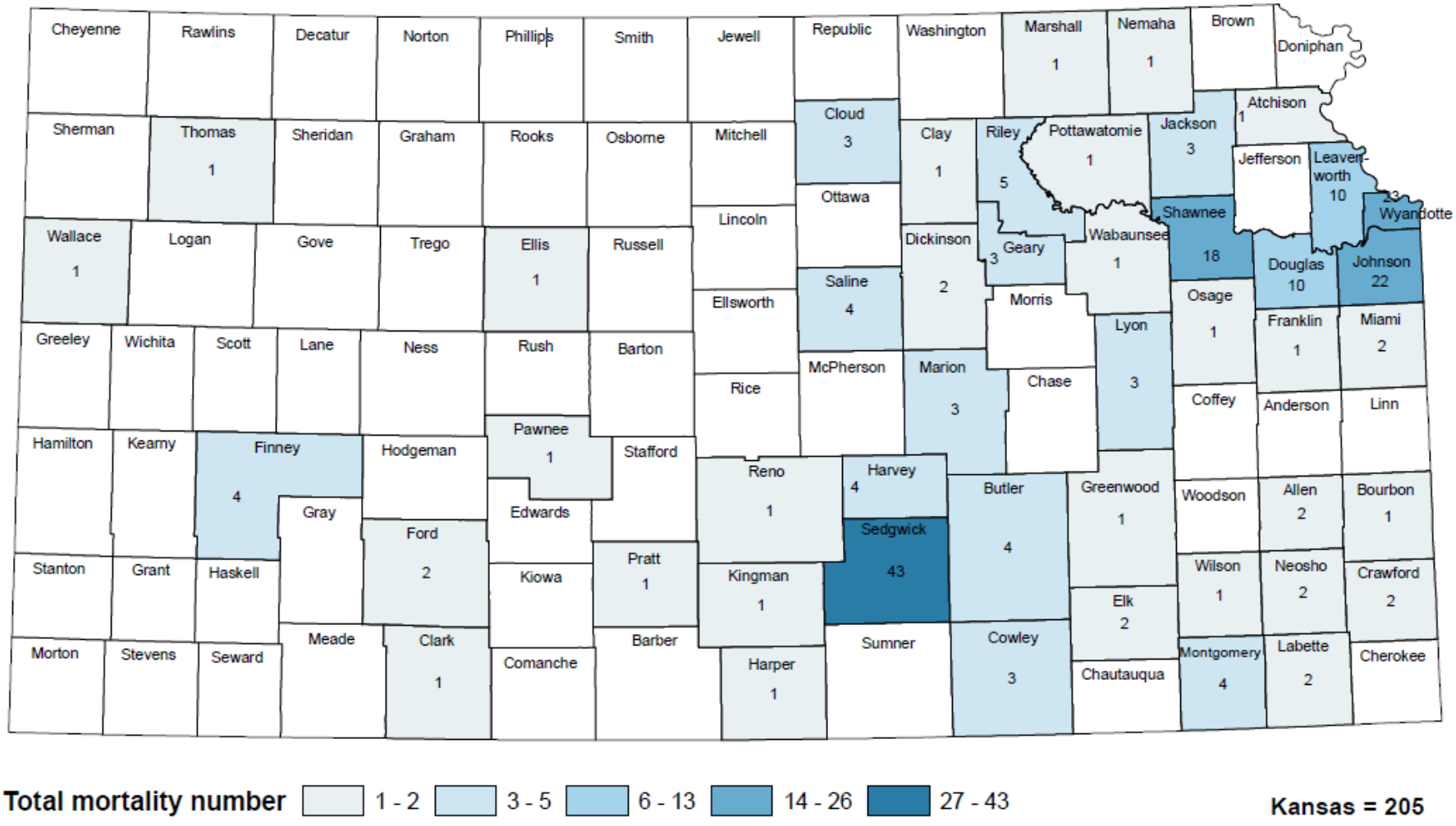
County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
Osage	18,473	9	48.72	7	1	0	1	0	0	0
Osborne	3,724	1	26.85	0	0	1	0	0	0	0
Ottawa	6,683	4	59.85	3	0	0	0	0	1	0
Pawnee	5,726	3	52.39	2	0	0	0	0	0	1
Phillips	6,112	1	16.36	1	0	0	0	0	0	0
Pottawatomie	34,702	9	25.94	6	0	1	1	0	1	0
Pratt	11,490	10	87.03	5	0	4	1	0	0	0
Rawlins	2,603	1	38.42	0	1	0	0	0	0	0
Reno	71,114	34	47.81	20	4	5	0	0	3	2
Republic	4,819	7	145.26	2	4	1	0	0	0	0
Rice	11,259	7	62.17	4	2	1	0	0	0	0
Riley	62,253	35	56.22	24	2	1	2	2	2	2
Rooks	5,686	2	35.17	1	0	0	0	0	1	0
Rush	3,123	1	32.02	1	0	0	0	0	0	0
Russell	7,576	2	26.4	0	1	0	0	1	0	0
Saline	64,639	33	51.05	20	1	3	1	5	2	1
Scott	6,502	0	0	0	0	0	0	0	0	0
Sedgwick	664,250	387	58.26	258	22	29	13	22	19	24
Seward	35,109	17	48.42	13	1	1	0	2	0	0
Shawnee	211,705	140	66.13	84	10	10	8	7	15	6
Sheridan	3,047	0	0	0	0	0	0	0	0	0
Sherman	7,131	4	56.09	1	1	0	0	0	1	1
Smith	3,630	2	55.1	2	0	0	0	0	0	0
Stafford	5,000	3	60	1	1	0	0	0	1	0
Stanton	2,811	2	71.15	1	0	1	0	0	0	0

*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

County	Population Age 0-17	Total Deaths*	Total Death Rate	Natural Deaths Excluding SIDS	Unintentional Injury-MVC	Unintentional Injury	SIDS	Homicide	Suicide	Undetermined
Stevens	8,240	5	60.68	3	1	0	0	1	0	0
Sumner	28,416	18	63.34	11	2	3	0	1	1	0
Thomas	9,059	7	77.27	3	0	1	0	0	2	1
Trego	2,641	1	37.86	0	0	0	0	0	1	0
Wabaunsee	8,254	5	60.58	2	0	0	1	0	2	0
Wallace	1,883	2	106.21	0	0	1	0	0	0	1
Washington	6,173	4	64.8	3	1	0	0	0	0	0
Wichita	2,818	1	35.49	0	1	0	0	0	0	0
Wilson	10,357	5	48.28	2	0	1	0	0	2	0
Woodson	3,321	2	60.22	2	0	0	0	0	0	0
Wyandotte	229,919	155	67.42	90	14	13	10	18	2	8
Out of State	-	105	-	61	24	8	1	6	4	1
Total	**2,833,700**	**1,960**	**69.17**	**1,179**	**191**	**178**	**80**	**100**	**133**	**99**

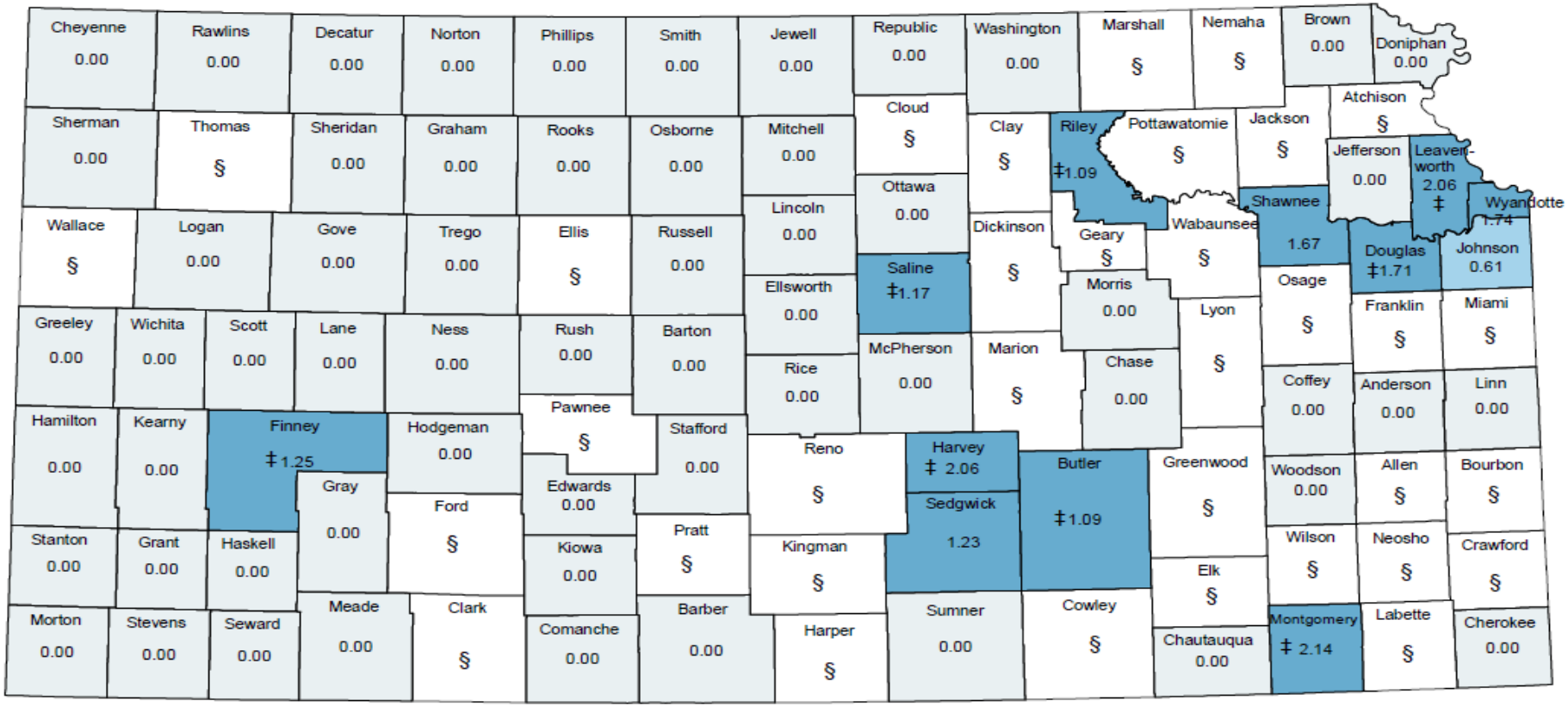
*Data based on 20 or fewer deaths are not statistically valid for intervention planning.

Appendix B: Sleep-Related Infant Deaths by County of Residence, 2015-2019



Source: Kansas State Child Death Review Board, 2015-2019

Appendix C: Sleep-Related Infant Death Rates by County of Residence, 2015-2019



RSE (Relative Standard Error): Defined as the estimate divided by its standard error, RSE is an indicator for statistical reliability.
‡ Estimates have a RSE greater than 30% and less than or equal to 50% and should be used with caution as they do not meet the standard of reliability or precision.
§ Estimates with a RSE of greater than 50% are replaced with a § and are suppressed.

Sources:
Numerator: Kansas State Child Death Review Board, 2015-2019
Denominator: Kansas Department of Health and Environment, Bureau of Epidemiology and Public Health Informatics. Kansas live birth data (resident), 2015-2019

Methodology

Kansas State Child Death Review Board 2019 Data

The SCDRB meets monthly to examine the circumstances surrounding the deaths of all Kansas children aged birth through 17 years old, as well as children who are not residents but died in Kansas. As a rule, the SCDRB is notified of a death when a death certificate, matched with its corresponding birth certificate, is received from the Kansas Department of Health and Environment's Office of Vital Statistics. On a monthly basis, KDHE provides the SCDRB with a list of children whose deaths have been reported as well as Kansas specific Birth and Death records as available for deaths occurring in Kansas. For deaths occurring out of state, The Kansas Office of Vital Statistics works with the Missouri Vital Records office to provide birth and death records to the SCDRB for deaths occurring in Missouri. For all other out of state deaths, the SCDRB is reliant on each individual state to report the death to the Board and share birth and death records as allowed. The reporting of all deaths of Kansas residents, whether occurring in Kansas or in another state is essential for cases to be consistently reviewed by the SCDRB.

When a death certificate is received, the SCDRB staff creates a file. Death and birth certificates, as well as the coroner information, are used to identify sources of additional information necessary for a comprehensive review. Before a case can be reviewed, pertinent records that could provide circumstances that led to the child's demise are collected for the file. Such records may include coroner reports, autopsy reports and photos, medical records, law enforcement reports, scene photographs, DCF records, school records, media reports and obituaries, and other relevant documents. Information obtained by the SCDRB is confidential.

After all records have been collected, cases are assigned for review and assessment. During the SCDRB's monthly meetings, members present their completed cases orally and discuss the circumstances leading to the death. If additional records are needed or specific questions are raised, a case may be continued to the next meeting. Upon agreement of the cause and manner of death, cases are finalized. In some instances, the SCDRB may determine that it is appropriate to refer a case to the county or district attorney in the county where the death occurred with recommendations for further action.

It should be noted that the numbers and rates in this report should not be expected to be the same as those reported in the KDHE Annual Summary of Vital Statistics, which monitors deaths of Kansas residents only. Case file information may not be available to the coroner when cause of death is determined, resulting in incomplete information about the circumstances of the death. After review by the Board, the classification of the cause or manner of death may be different from that determined by the coroner.

The current reporting of data follows the custom of presenting death rates for infants per 1,000 live births, and death rates for all other age groups per 100,000 age-group population. The exception to this rule is when rates for infants and older children are compared in the same graph. In such an instance, infant mortality is expressed as deaths per 100,000 infant population.

To determine the infant death rate per 1,000 live births in a specific year, the number of deaths is divided by the corresponding number of live births, and then multiplied by 1,000.

The KDHE Bureau of Epidemiology and Public Health Informatics (BEPHI) is the source for numbers of live births used as denominators in this report.

Example: Infant death rate, Kansas 2019 =

$$\left(\frac{\text{203 (number of infant deaths that occurred in 2019, reviewed by the SCDRB)}}{\text{35,395 (number of Kansas resident live births in 2019)}} \right) \text{ X } 1{,}000$$

$$= 5.7$$

To determine the death rate per 100,000 population for an age group for a given time period, the number of deaths is divided by the corresponding population, and then multiplied by 100,000. The KDHE BEPHI is the source for numbers of resident population data used as denominators in this report.

Example: Motor Vehicle Death Rate, age 15-17, Kansas 2019 =

$$\left(\frac{\text{8 (number of MVC deaths age 15-17 that occurred in 2019, reviewed by the SCDRB)}}{\text{118,653 (population of Kansas residents age 15-17 in 2019)}} \right) \text{ X } 100{,}000$$

$$= 6.7$$

Lastly, several figures throughout this report contain data based on small numbers. Rates and percentages based on small numbers can be unreliable due to random error and should be used with caution.

The information and data contained in this report are compiled from multiple reporting sources and have been represented to be accurate as of the date of this report. The information and data contained herein are subject to later modification by the reporting sources.

Any questions about this report or about the work of the SCDRB should be directed to Sara Hortenstine, Executive Director, at (785) 296-7970 or by e-mail at sara.hortenstine@ag.ks.gov

Goals and History

The State Child Death Review Board (SCDRB is charged with reviewing all deaths of children ages birth through 17 years old who die within Kansas and Kansas residents in that age group who die outside the state. The Board works to identify patterns, trends and risk factors, and to determine the circumstances surrounding child fatalities. The ultimate goal is to reduce the number of child fatalities in the state.

The Board is unique in its duties as it is the only entity in the State of Kansas that conducts a thorough review of each child death by analyzing medical records, law enforcement reports, social service histories, school records, and other pertinent information including birth certificate, death certificate and autopsy findings. The information collected is maintained confidentially and is used to review and analyze the circumstances of each child's death. This review allows the Board to assist other agencies in prioritizing education and prevention efforts. The Board members and staff collaborate with other agencies on child safety issues, testify on pertinent legislation, conduct trainings, and serve on committees and task forces in an effort to support the work of protecting Kansas children.

The SCDRB has developed the following three goals to direct its work:

1) To describe trends and patterns of child deaths (birth through 17 years old) in Kansas and to identify risk factors in the population;
2) To improve sources of data and communication among agencies so that recommendations can be made regarding recording of the actual cause of death, investigation of suspicious deaths, and system responses to child deaths. This interagency communication should occur at the individual case level and at the local and state levels; and
3) To develop prevention strategies including community education and mobilization, professional training, and needed changes in legislation, public policy and/or agency practices.

The SCDRB was created by the 1992 Kansas Legislature and is administered by the Office of the Kansas Attorney General. SCDRB membership is appointed according to K.S.A. 22a-241 et. seq. Membership includes: one member each from the Office of the Attorney General, the Kansas Bureau of Investigation (KBI), the Department for Children and Families (DCF), the Kansas Department of Health and Environment (KDHE), and the Department of Education; three members appointed by the Board of Healing Arts: a district coroner, a pathologist, and a pediatrician; one representative of a child advocacy group appointed by the Attorney General; and one county or district attorney appointed by the Kansas County and District Attorneys Association.

This multi-disciplinary volunteer Board meets monthly to examine circumstances surrounding the deaths of Kansas children. Members bring a wide variety of experience and perspective on children's health, safety and maltreatment issues, which strengthen the decision-making of this body.

With assistance from agencies around the state, the SCDRB is given necessary information needed to examine the circumstances that led to the deaths of children. By understanding how children are dying, the SCDRB is able to propose ways of reducing the number of preventable death.

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